DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	(X3) DATE SURVEY COMPLETED 04/06/2011	
	PROVIDER OR SUPPLIER		701 S C	ADDRESS, CITY, STATE, ZIP C DAK STREET IESTER, IN47394	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F0000	State Licensure Sincluded the Investination Investigation	: 155231 00275450 e, R.N., TC , R.N. , R.N.	F0000			
LABORATOR	Y DIRECTOR'S OR PROV	'IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ11

Facility ID:

000136

If continuation sheet

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ANDILAN	OF CORRECTION	155231	A. BUILDING	00	04/06/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			DAK STREET	
	PH NURSING HOM			IESTER, IN47394	
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	Supplemental Sa	mpic. I			
		es also reflect state accordance with 410 IAC			
	Quality review co Cathy Emswiller	ompleted 4-12-11 RN			
F0157	resident; consult wand if known, notification representative or a member when the the resident which the potential for reintervention; a sign resident's physical status (i.e., a deteor psychosocial status (inc., a deteor psychosocial status (inc.	nificant change in the I, mental, or psychosocial rioration in health, mental, atus in either life ions or clinical need to alter treatment a need to discontinue an eatment due to adverse to commence a new form decision to transfer or dent from the facility as			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	BUILDING COMPLETED			
		155231	B. WIN	G		04/06/2	011
			<u>.</u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	ROVIDER OR SUPPLIER			701 S C	OAK STREET		
RANDOL	PH NURSING HOM	1E		WINCH	IESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	paragraph (b)(1)	of this section.					
SS=G	update the addres resident's legal rep family member.	ecord and periodically as and phone number of the presentative or interested review and interview, the	F0	0157	F157 Preparation and/or		04/22/2011
SS=G	facility failed to oppromptly notified fever and/or a charcesulting in hospifor sepsis, wound tract infection for tracheostomy revenotification of a complications in (Resident #70) Findings include 1. The clinical rewas reviewed on Diagnoses for Rewere not limited pneumonia, chrowith status post that and diabetes melindicated the resilier via a gastrostomy catheter, had a cowound vac in pla repair of a sacral	ecord for Resident #70 4/3/11 at 4:00 p.m. esident #70 included, but to, history of aspiration nic respiratory failure racheostomy, paraplegia, litus. The clinical record dent received nutrition y tube, had an anchored plostomy, and had a nice related to the surgical decubitus.	F0	0157	execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission agreement by Randolph Nursing Home of the facts alleged or conclusions set fort this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and feddlaws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. This facility informs the resident physician of significant change in resident condition. Corrective action for residents cited as affected. Resident #70 Physicia was notified and resident was sent to the Emergency Room evaluation on 4-3-11 at 9:30 per light least of the potential to be affected. Resident at risk; All residents have the potential to be affected. Resident every even at the development of fever or change in sputum color. Licensed nursing staff will use Condition Change form for documentation of residents with the development of residents	h in eral of nt's es ve an for .m. ts dent ure g	04/22/2011
	-	decubitus.			Condition Change form for	10	

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sputum, inner canula changed times 2" sputum, inner canula changed times 2" staff will use the condition change form, for documenting assessment of vital signs and	sputum, inner canula changed times 2" A nursing note, dated 3/30/11 at 4:00 p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had staff will use the condition change form, for documenting assessment of vital signs and physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of						change on the 24 hour nursing	,	
A nursing note, dated 3/30/11 at 4:00 form, for documenting assessment of vital signs and	A nursing note, dated 3/30/11 at 4:00 p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had form, for documenting assessment of vital signs and physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of		I -						
A nursing note, dated 3/30/11 at 4:00 assessment of vital signs and	A nursing note, dated 3/30/11 at 4:00 p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had assessment of vital signs and physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of		sputum, inner ca	nuia changea times 2"				nge	
I I indising note, duted 5/50/11 at 4.00	p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had physician notification for residents who have developed a fever and/or a change in sputum color, to ensure communication of		_						
	p.m., indicated the resident had developed a temperature of 101.3 (type of temperature not noted) and Tylenol had who have developed a fever and/or a change in sputum color, to ensure communication of		A nursing note, of	dated 3/30/11 at 4:00			_	onte	
	a temperature of 101.3 (type of temperature not noted) and Tylenol had and Tylenol had and Tylenol had and Tylenol had		p.m., indicated the	he resident had developed				51115	
	temperature not noted) and Tylenol had to ensure communication of		a temperature of	101.3 (type of			•	or.	
			· •				I	- · ,	
	I DOUT RIVER. THE HOLE HIGHERE THIRS I FOR STANDARD IN THE PROPERTY OF THE		1 *				physician notification and		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE crackles in lower lobes...." A follow-up intervention for fever or change in sputum color. (attachment A) note at 8:00 p.m. indicated the resident's The DON or designee will review temperature was now 100.9 and Tylenol the 24 hour daily report and was given. review the change in condition monitoring log and nurses notes of residents noted to have A nursing note, dated 3/31/11 at 2:15 experienced a change in p.m., indicated the resident's temperature condition, and assure appropriate was 100.2. physician notification of significant condition change. Monitoring of corrective action; The Director of A nursing note, dated 4/1/11 at 4:30 a.m., Nursing or her designee will, each indicated "...lungs diminished...trach care day, review the daily 24 hour given with yellow thick sputum noted...." report for resident change in condition and the change in condition monitoring form with the A nursing note, dated 4/2/11 at resident's medical chart to ensure 10:30 p.m., indicated the resident nursing staff are appropriately notifying the resident's physician had a temperature of 102.9 axillary regarding a fever or change in and Tylenol was given. A follow sputum color. The Director of Nursing will monitor to assure up temperature taken at 12:30 a.m. appropriate physician notification on 4/3/11 was 101.7 axillary and through review of 24 hour report the resident's respiratory rate was and new physician orders during the morning Interdisciplinary (IDT) 20 breaths per minute. meeting. This audit will occur 5x weekly for 30days, 3x weekly for 30 days 1x weekly for 90days in A nursing note, dated 4/3/11 at total. Findings will be reported to 10:30 a.m., indicated the resident's the QA&A team on a weekly basis to ensure timeliness of temperature was 102 and Tylenol notification of a physician if a was given. The resident's resident has developed a fever respiratory rate was 20 breaths per and/or a change in sputum color. These monitors will minute become part of Randolph Nursing Home's Quality Assurance program to assure all patients A nursing note, dated 4/3/11 (a with a change in condition are Sunday) at 3:00 p.m., indicated reported and conveyed to the

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	ULTIPLE CO LDING	00	COMPLE	ETED
		155231	B. WIN			04/06/20)11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DAK STREET		
RANDOL	.PH NURSING HON	ΛΕ		1	IESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JE	COMPLETION
TAG		e of doctor] office r/t		TAG	physician timely. This review	will	DATE
	-	-			continue on as part of Randol		
	(related to) cur	rrent status.			Nursing Homes Quality Assurance Program.		
	The nursing no	otes from 3/28/11					
	through 4/3/11	at 3:00 p.m. lacked					
	any information	on related to the					
	physician bein	g notified of the					
	resident's yello	ow sputum and/or					
	elevated tempe	erature prior to the					
	info (informat	ion) being sent to the					
	physician's off	fice on Sunday 4/3/11					
	noted above.	This indicated a time					
	period of 6 day	ys from the date the					
	•	oped the thick yellow					
		was later followed					
	_	ment of an elevated					
		nd the physician was					
	notified of the						
	condition.	S					
	The next nursi	ng note was dated					
		p.m. and indicated					
		re]102.6 axillary.					
		es heard in bilat					
	(bilateral) lung	gs. Res [resident]					
	coughing up d						
		he note indicated the					
		iratory rate was 40					
	•	was 134 beats per					
		-			L		

minute. The note indicated the resident's physician was paged at that time. A follow-up note at 9:00 p.m. indicated the physician was paged again. A nursing note, dated 4/3/11 at 9:30 p.m., indicated information on the resident's condition had been given to the physician and an order was received to send the resident to the emergency room for evaluation. A follow-up note at 10:00 p.m. indicated the resident had been taken from the facility via ambulance to the hospital.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MUL A. BUILD B. WING		00	(X3) DATE COMPI 04/06/2	ETED	
SUMMARY STATEMENT OF DEFICIENCIES TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION MINUTED BY PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG minute. The note indicated the resident's physician was paged at that time. A follow-up note at 9:00 p.m. indicated the physician was paged again. A nursing note, dated 4/3/11 at 9:30 p.m., indicated information on the resident's condition had been given to the physician and an order was received to send the resident to the emergency room for evaluation. A follow-up note at 10:00 p.m. indicated the resident had been taken from the facility via ambulance to the hospital.					701 S O	AK STREET	•	
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During an interview on 4/4/11 at 9:00 a.m., LPN #5 indicated Resident #70 had been sent to the hospital "last night" due to an elevated temperature and condition change and had been admitted for treatment. During an interview with the Director of Nursing on 4/6/11 at 10:50 a.m., indicated she had	TAG	minute. The resident's physical time. A final paged again. A nursing note p.m., indicated resident's condition to the physicial received to see emergency roof follow-up note indicated the retaken from the ambulance to During an interpretated temperature of the physicial page. The physicial page and has treatment.	e, dated 4/3/11 at 9:30 d information on the dition had been given an and an order was and the resident to the form for evaluation. A se at 10:00 p.m. resident had been at facility via the hospital. Erview on 4/4/11 at N #5 indicated had been sent to the night" due to an erature and condition ad been admitted for		TAG			DATE

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIER		p. wate	STREET A	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	#70's admission resident had be diagnosis of perfevers and work	n related to Resident on. She indicated the een admitted with the cossible sepsis with and infection and a affection had been ne testing was					
	p.m., additional requested related physician notification.	on 4/4/11 at 4:00 al information was sed to the delay in fication of the change as sputum and the of an elevated					
		iled to provide any rmation as of exit on					
SS=G	2.) Refacility 4/27/0 DoN o	view of a current y policy created 8, provided by the on 4/4/11 at 4:35 itled "PHYSICIAN			F157 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admissi or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth this statement of deficiencies. The plan of correction and		04/22/2011

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	A. BUILDING 00			(X3) DATE SURVEY COMPLETED 04/06/2011
	PROVIDER OR SUPPLIER		B. WIN	701 S (ADDRESS, CITY, STATE, ZIP CODE DAK STREET JESTER, IN47394	04/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
	NOTI	FICATION VIA			specific corrective actions are prepared and/or executed in	
	FACS	IMILE", included,			compliance with state and fed laws. Please accept this plan	I
	but wa	as not limited to, the			correction as our credible	
	follow	ing:			allegation of compliance with all regulatory requirements. This facility informs the reside physician of significant change	nt's
	"PURPO	SE:			in resident condition. Corrective action for residents cited as	<u>/e</u>
	Establ	ish guidelines and			affected Resident #70 Physici was notified and resident was	an
	directi	on to notify			sent to the Emergency Room evaluation on 4-3-11 at 9:30 p	I
	physic	ians by fax			Identification of other resider	I
	1 2	nission.			at risk; All residents have the potential to be affected. Residue records were reviewed to assi	
	POLICY				physician notification regardin the development of fever or change in sputum color. Licensed nursing staff will use Condition Change form for	
	The physic	ian will be notified of			documentation of residents wh	
	certain conditi				have developed a fever and/o change in sputum color in ord-	
	•	is policy. Certain			to ensure timeliness of physic	l l
		tions may require			notification and interventions a in place for change in conditio	I
		ention by phoning the			(attachment A) All nursing state	I
	physician or o	n-call physician			will use form (attachment A) a an in-house tool for charting ir	I
	2 F :				nurses notes for all residents	who
	2. Faxing m	•			have developed a fever and/o change in sputum color in order	I
		only occur if the			to ensure timeliness of physic	ian
	condition does	-			notification and interventions a in place for all change in	are
	immediate atte	ention			conditions. Measures to ensure	<u>e</u> _
					this deficient practice does no recur; Nursing staff will be	
					lecal, maising stall will be	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155231	B. WIN			04/06/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	E .		701 S C	OAK STREET		
	_PH NURSING HON				ESTER, IN47394		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	•	ns that require		TAG	re-inserviced as of April 22, 20)11	DATE
	3. Conditions that require immediate attention will not be				to 1.) Change in Condition		
					Monitoring log, 2.) Physician		
		would include, but			Notification Parameters and policy 3.) Process for physicia	n	
	are not limited	l to: chest pain,			notification including physician		
	deformities w	ith obvious fracture,			notification via facsimile and th		
		in pain, swelling or			process for situations requiring immediately informing a reside		
	bruising, conf	usion of sudden onset			s physician of a significant		
	_	ries. The nurse will			change in a resident condition		
	1	sician immediately			4.) Documentation of change of	of	
		·			condition and physician notification utilizing the Chang	e in	
	and document	accordingly"			Condition Monitoring flow shee		
					and documentation of conditio		
					change on the 24 hour nursing		
					report. (Attachment C) Nursing		
					staff will use the condition cha form, for documenting	nge	
		6 1 1			assessment of vital signs and		
	3.) Review (of a current undated			physician notification for reside	ents	
	facility police	ey, provided by the			who have developed a fever		
	1	ant on 4/6/11 at			and/or a change in sputum coll to ensure communication of	or,	
					physician notification and		
	11:00 a.m., 1	titled "PHYSICIAN			intervention for fever or chang	e in	
	NOTIFICAT	ΓΙΟΝ			sputum color. (attachment A)		
	PARAMETI	FRS			The DON or designee will revi	ew	
					the 24 hour daily report and review the change in condition	,	
	DEFINITIO	NS", included, but			monitoring log and nurses not		
	was not limi	ted to, the			of residents noted to have		
	following:				experienced a change in	iato	
	Tono wing.				condition, and assure appropr physician notification of signification		
					condition change. Monitoring		
	"1. IMMEI	DIATE			corrective action; The Director	of	
	NOTIFICATION	ON: A physician			Nursing or her designee will, e	ach	
	should be info	ormed at the time the			day, review the daily 24 hour report for resident change in		
		lirectly or via an			condition and the change in		
	oveni occurs c	incomy of via all					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/06/2011	
	PROVIDER OR SUPPLIER		701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET IESTER, IN47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	electronic or to	elephone call		condition monitoring form with resident's medical chart to ens	sure
	Condition			nursing staff are appropriately notifying the resident's physici regarding a fever or change in sputum color. The Director of Nursing will monitor to assure	an f
	Immediate			appropriate physician notificat through review of 24 hour repo and new physician orders duri	ort
	Vital signs			the morning Interdisciplinary (I meeting. This audit will occur to weekly for 30days, 3x weekly	5x ´
	Oral temp: > Temp: > 102 d	101 degrees Rectal legrees"		30 days 1x weekly for 90days total. Findings will be reported the QA&A team on a weekly b to ensure timeliness of	in d to
	3.1-5(a)(2) 3.1-5(a)(3)			notification of a physician if a resident has developed a feve and/or a change in sputum color. These monitors will become part of Randolph Nurs Home's Quality Assurance program to assure all patients with a change in condition are reported and conveyed to the physician timely. This review v continue on as part of Randolphursing Homes Quality Assurance Program.	sing
F0206	written policy under hospitalization or the bed-hold perior readmitted to the the first availability of room if the resider	nust establish and follow a er which a resident whose therapeutic leave exceeds of under the State plan, is facility immediately upon the a bed in a semi-private nt requires the services cility; and is eligible for facility services.		_	
SS=D		review and interview the allow 2 of 4 residents in a	F0206	F206 Preparation and/or execution of this plan of correction in general, or this	04/22/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPLE	
		155231	B. WIN	IG		04/06/20)11
NAME OF	PROVIDER OR SUPPLIEF	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THINE OF	ROVIDER OR SOTTEIET	•		701 S C	DAK STREET		
RANDOI	_PH NURSING HON	ME		WINCH	IESTER, IN47394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sample of 16 ret	urn to the facility after a			corrective action in particular,	_	
	stay in an acute	care facility. [Resident #'s			does not constitute an admiss	ion	
	C and D]				or agreement by Randolph		
					Nursing Home of the facts alleged or conclusions set fort	h in	
	Findings include	a·			this statement of deficiencies.	'' "'	
	Tilldings illerad	C.			The plan of correction and		
					specific corrective actions are		
		s clinical record was			prepared and/or executed in		
	reviewed on 4/4/	11 at 2:50 p.m. The			compliance with state and fed	eral	
	resident's diagno	ses included, but were			laws. Please accept this plan	of	
	not limited to, Ps	sychosis; mood disorder;			correction as our credible		
		ia; deaf and mute.			allegation of compliance with	ו	
					all regulatory requirements.		
	The resident had	a 3/2/11, telephone			Residents are readmitted to the		
					facility following hospitalization therapeutic leave in accordance		
		for Resident #D to be			with state and federal guideling		
		nergency room for			for readmission. Corrective ac		
	possible psychia	tric placement.			for affected residents Residen		
					#C and Resident #D are residi		
	Review of the 3/	2/11, 7:45 a.m., Nurse's			in a Long Term Care Facility,		
	Note indicated the	ne resident forcefully			Parkview in Muncie Indiana.		
		irse on the face when the			Nursing staff and Administrative		
		o the resident he needed			personnel will be re-inserviced		
					of April 22, 2011 to Federal Ta F206 and the state bed hold	9	
	to adjust his clot	ning.			policy including readmission, of	of	
	.				Medicaid-eligible residents, wh		
		11, Social Services			are on therapeutic leave or		
	1 ~	dicated the Social Service			hospitalized, to the first availal	ole	
	_	otified on 3/3/11 of the			bed. see (Attachment C)		
	resident's behavi	or on $3/2/11$. The note			Identification of other residents		
	indicated the res	ident was admitted to the			risk; All discharged residents a	are	
	psychiatric unit.				at risk. Audit of discharged residents was completed April		
	r = J =================================				22, 2011 ensuring placement		
	During an intarr	iew with the Discharge			each resident was found and		
	1	· ·			appropriate discharge informa	tion	
		patient Geri-Psch Unit on			communicated to the		
		m., she indicated she had			Responsible party. see		
	updated the facil	ity of Resident D's			(Attachment I) Nursing staff a	nd	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE progress during his stay on the unit. She Administrative personnel will be re-inserviced April 22, 2011 to indicated she notified the facility the Federal Tag F206 and the State's resident was stable and could return to the Bed-hold policy which includes facility. She indicated the facility refused readmission, of Medicaid-eligible residents on therapeutic leave or to readmit the resident and did not assist hospitalized, to the first available in finding a new placement for the bed. (Attachment C) Measures to resident. ensure this deficient practice does not recur; Nursing staff and During an interview with the Administrative personnel will be re-inserviced April 22, 2011 to Administrator and Social Service Federal Tag F206 and the State Designee on 4/5/11 at 3:50 p.m., they and facility Bed Hold Policy. indicated they did not readmit the resident including all Medicaid-eligible to the facility due to not being able to residents who are on therapeutic leave or hospitalized be meet the resident's needs. They indicated readmitted to the first available the resident had been out to a psychiatric semi private bed. (Attachment C) unit in February, 2011 and readmitted Monitoring of corrective action; The Social Service after that stay. They indicated the resident Director or designee will monitor would become aggressive without resident discharges to ensure provocation. The Social Service appropriate placement of Designee indicated the resident was not discharged resident and meeting his Care Plan Goal of "I will not appropriate discharge or readmission information hit other people, if I become angry I will communicated to the remove myself from the situation that is Responsible party utilizing a upsetting me." QA&A tool. (Attachment I). This Discharge QA&A audit will be completed on every discharged 2. Resident #C's clinical record was resident with any concerns reviewed on 4/4/11 at 12:50 p.m. The reported immediately to the resident's diagnoses included, but were facility administrator. Results of not limited to, dementia with behavioral QA&A discharge placement and resident/ responsible party disturbances, personality disorders, and notification monitor will be mood disorder. reported to the QA&A team weekly, and will become part of The resident had a 2/16/11, Physician's Randolph Nursing Homes Quality Assurance Program. order for the resident to be transferred to

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Event ID:

EPSJ11

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAIN	OF CORRECTION	155231	A. BUI		00	04/06/2	
		100201	B. WIN		A DDDEGG CITY GTATE ZID CODE	04/00/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HOM	ΛΕ			ESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the emergency ro	oom for a psychiatric					
	evaluation and tr	eatment.					
		5/11, Social Service					
	•	licated the resident was					
		in-patient psychiatric					
		crease in unwarranted					
	accusations again	nst staff members.					
	During an intervi	iew with the Discharge					
	~	patient Geri-Psych Unit					
	1	a.m., she indicated she					
		facility of Resident C's					
		ner stay on the unit. She					
		tified the facility the					
		ele and could return to the					
		icated the facility refused					
	l *	sident and did not assist					
		placement for the					
	resident.	pracement for the					
	resident.						
ı	During an intervi	iew with the					
	Administrator an						
	Designee on 4/5/	11 at 3:50 p.m., they					
		d not readmit the resident					
	to the facility due	e to not being able to					
	meet the resident	s's needs. They indicated					
	the resident had l	been out to a psychiatric					
	unit in December	r, 2010 and readmitted					
	after that stay. T	they indicated the resident					
	had increased bel	haviors of threatening the					
	staff and making	false accusations against					
	the staff.						

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE (COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIER			701 S O	DDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	This Federal tag #IN00087993.	relates to complaint					
	3.1-12(a)(27)(A) 3.1-12(a)(27)(B)						
F0223	verbal, sexual, phy	he right to be free from ysical, and mental abuse, ent, and involuntary					
SS=G	sexual, or physica punishment, or inv	ot use verbal, mental, I abuse, corporal oluntary seclusion. review and interview the	F0	223	F223 Preparation and/or		04/22/2011
30-0	facility failed to a facility policy rel with a felony cor years for 1 of 5 a (Employee CNA incidents of residents of residents investigated, fail verbal abuse to the authority, failed a were implemented incidents of verbal residents reviewed secured dementiation of the physical abuse (Incidents of physic	develop and implement a ated to hiring employees aviction within the last 5 employee files reviewed. #1), and failed to ensure ent verbal abuse were dministrator, failed to of verbal abuse were ed to report incidents of the appropriate state to ensure interventions and to prevent further all abuse for 2 of 2 and who resided on the a unit who were subjected Resident #'S 39, 45,), eect 1 of 1 resident from the esident #29) which were of 1 resident reviewed		223	execution of this plan of correction in general, or this corrective action in particular, does not constitute an admissi or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. This facility has policy and procedures in place to promote the resident right to be free fro abuse. Corrective action for affected residents Employee # was terminated. see (Attachmet K) Residents #39 & #45 were	eral of m	04/22/2011

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155231	A. BUI	LDING	00	04/06/2	
		199231	B. WIN			04/00/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	DAK STREET		
RANDOL	PH NURSING HO	ME		WINCH	IESTER, IN47394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	for verbal and pl	nysical abuse in a sample			interviewed for psychosocial		
	of 16. (Resident	#E)			outcomes of potential verbal abuse with no negative outcor	me	
					noted by either resident.	iie	
					Residents #39 & #45 physicial	ns	
	Findings include	: :			and families were notified of th		
					verbal abuse, a report was sei	nt to	
	1.) Review of the	ne current undated facility			Indiana State Department of		
	· ·	cidents of Alleged Abuse"			Health. Resident #E is on		
		e administrator on 4/4/11			One-to-One supervision until further notice. April 20, 2011		
		icated the following,			Social Service Director was		
	at 9.13 a.m., mu	icated the following,			re-educated to policy and		
					procedure of Behavior Mgt,		
	" Purpose:				including identifying a resident	's	
					problem behavior including bu	t	
	To ensure that ea	ach resident is free of			not limited to Physical and/or		
	physical, mental	, verbal and sexual abuse,			verbal aggressive. Identify	ina	
	corporal punishr	nent, mental and physical			precipitants to behavior includ people involved, environment,	-	
	neglect, and invo	oluntary seclusion.			verbal and non-verbal Behavio		
	1	not be subjected to abuse			using a log to track behaviors		
		ding, but not limited to,			precipitating factors, education	า	
	1 * *	er residents, consultants			staff in manner of approaching		
					resident and documentation of		
		aff of other agencies			these findings on the Care Pla		
		ent, family members or			(Attachment C) April 22, 2011 nursing staff and managers we		
	legal guardians,	friends or other			reeducated to abuse recognition		
	individuals.				intervention, and reporting of	,	
					resident abuse. Identification	<u>of</u>	
	Policy:				other residents at risk; All		
					employee files have been		
	Residents residing	ng in this facility will be			reviewed to ensure all employ have not been convicted of a	ees	
		nity and respect in			felony conviction within the las	t l	
		their individual needs.			5years. (Attachment L) Resid		
		subjected to physical,			#E's chart was reviewed for		
	I	nd sexual abuse, corporal			indication of potential occurrer		
	· ·	• •			of verbal and/or physical abus	е.	
	_	ntal and physical neglect,			Resident and staff interviews		
	and involuntary	seciusion.			were completed April 22, 2011		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155231	B. WIN			04/06/2	011
		I	-		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			OAK STREET		
RANDOL	PH NURSING HO	ΜE		1	IESTER, IN47394		
(V4) ID	CLIMMADY	TATEMENT OF DEFICIENCIES			, 		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG	REGULATORY OR	LISC IDENTIFFING INFORMATION)	-	IAG			DATE
					with no finding indicating occurrence of abuse. All staff		
	"Abuse" is the w	villful infliction of injury,			have been re-inserviced		
	unreasonable con	nfinement, intimidation,			regarding recognition,		
	or punishment w	rith resulting physical			intervention and reporting		
	_	mental anguish, or			incidents of alleged abuse.		
	1 ^	n individual, including a			(Attachment C)Measures to		
		ods or services that are			ensure this deficient practice		
	, ,				does not recur; All employee f		
	1	in or maintain physical,			have been reviewed to ensure		
		chosocial well being. This			employees that have been him	ed	
	presumes that in	stances of abuse of all			have not been convicted of a felony conviction within the las	. +	
	residents, even the	hose in a coma, cause			5years. (Attachment L).	ol .	
	physical harm, o	r pain or mental anguish.			Bookkeeper or designee will		
					monitor criminal background		
	Physical Abuse:				check of all applicants prior to		
	i ilysical Abusc.				employment utilizing the		
					Employee Pre-Employee		
		not limited to, hitting,			Screening Policy. Findings wi		
	slapping, punchi	ng, kicking, etc. It also			reported to facility administrate		
	includes controll	ing behavior through			who will confirm persons with		
	corporal punishr	nent.			criminal conviction in the past years are not hired. All staff		
					years are not hired. All staft have been re-inserviced		
	Verbal Abuse:				regarding recognition,		
	verbar ribuse.				intervention and reporting		
	Dafama (incidents of alleged abuse.		
	1	e of oral, written, or			(Attachment C)Social Service		
	gestured languag				Director was re-educated Apri		
		derogatory terms to			2011 to policy and procedure	of	
	residents or their	families, or within			Behavior Management,		
	hearing distance	, to describe residents			(Attachment C); including	m	
	regardless of the				identifying a resident's probler behavior including but not limi		
	1	lisability. Examples of			to physical and/or verbal	iou	
	_	lude, but are not limited			aggressive behaviors. Identify	ying	
					precipitants to behavior, using	-	
		m, saying things to			log to track behaviors and		
	1 -	nt, such as telling a			precipitating factors, education		
	resident that he/s	she will never be able to			staff in manner of approaching	9	
	see his/her famil	v again			resident and updating the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE resident's Care Plan.Resident charts will be reviewed, by April Mental Abuse: 22, 2011, to ensure awareness and appropriate action for Includes, but is not limited to, behaviors of Physical and/or verbally aggressive or socially humiliation, harassment, threats of inappropriate or disruptive punishment or deprivation. The behaviors. (attachment I) April 22, procedures for reporting and documenting 2011, Nursing staff and managers mental abuse are the same as reporting were reeducated to abuse physical abuse.... recognition, intervention, and reporting of resident abuse. Monitoring of corrective Procedure: action: On April 6, 2011 Resident #E was placed on one-to-one Should any type of abuse or alleged abuse monitoring until further notice Social Service Director will occur, the following procedure is to be track behaviors and precipitating followed: factors, review with the IDT to develop care plan and educate staff to preventative interventions. 1. Any staff member witnessing an All Charts will be reviewed, by incident of physical, verbal, mental or April 22, 2011, to ensure sexual abuse, must intervene on behalf of awareness and appropriate action resident. for behaviors of Physical and/or verbally aggressive or socially inappropriate or disruptive 2. After the resident's immediate safety is behaviors. (attachment I) The ensured, the staff member must then Social Service Director or her report the incident to the staff member in designee will monitor to assure charge of the facility at the time of the use form (Attachment I) 5x weekly for 30days, 3 times weekly incident. (If administrator is not in the for 30 days, 1x weekly for 90 days building at the time of the incident, he/she in total. Findings will be reported will be notified immediately by the person to the QA&A team for review in charge.)... weekly. The Bookkeeper or designee will monitor all applicants for felony conviction 3. A thorough investigation is intimated of status prior to employment and the allegations to gather pertinent report findings of felony information and verify the occurrence. conviction to administrator (Attachment L). Facility

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155231	A. BUI	LDING	00	COMPLI 04/06/20	
		100201	B. WIN			04/06/20	711
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RANDOL	PH NURSING HOM	Λ F		1	DAK STREET ESTER, IN47394		
		TATEMENT OF DEFICIENCIES			I		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, i	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
	4. There must be	appropriate steps taken			administrator will assure perso	ns	
		r (potential) abuse while			with a felony conviction are		
	the investigation	•			reviewed are hired or decline employment per Pre-Employm	ont	
		1 0			Screening Policy. Employees		
					with a felony conviction within	the	
	2) .The clinical re	ecord for resident #E was			past five years are ineligible fo		
	reviewed on 4/3/	11 at 4:30 p.m.			hire. Findings will be reported the QA&A team at least	io	
					quarterly. This process will		
	Resident #E's cui	rrent diagnoses included,			become part of Randolph Nursin		
	but were not limi	ted to, Huntington's			Homes Quality Assurance Progra	m.	
	disease, mood di	sorder and dementia with					
	agitation.						
		a current healthcare plan,					
	l ~	4/26/10, and was					
	^	which indicated the					
	1	oblem listed as, resident					
	*	becoming abusive to					
	others.						
		this problem included,					
		naviors, interventions					
	used and the resid	*					
	interventions use	a.					
	Nursing note ont	ries from Resident #E's					
	_	dicated the following,					
		areated the followilly,					
	10/29/10 at 5:00	p.m., "resident has been					
		other residents at table					
	•	tried to redirect resident					
		very hateful cursing at					
		leave dining room when					
		continued to talk bad to					
	tablemate. Socia	al service made aware."					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155231	B. WIN			04/06/2	U11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HON			1	ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
					CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	
PREFIX TAG	10/30/10 at 3:00 verbally taunting [dining room] take ugly, I'd just show redirect resident. behaviors." 10/31/10, at 3:00 behaviors when (called other resident worthless, other reback, attempted to [without] success 11/1/10 at 10:00 other res [resident [breakfast], unabeleave DR, calling [homosexual], state head, "ugly"." 11/6/10 at 2:00 p [continues] [with calls tablemate going to shoot you man, other resident comments." 11/7/10 at 6 p.m. [continued] behat called other resurgunt o shoot other shoot shoot other shoot other shoot other shoot s	p.m. "Continues [with] a [at] table in DR. lent gay, ugly and resident did not respond to redirect resident s." a.m.,"very rude to at] during bkfst le to redirect, refused to		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
	Provono omor ro	o to this is opin proof cup					

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l	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 04/06/	LETED
	PROVIDER OR SUPPLIEE		701 S C	DDDRESS, CITY, STATE, ZIP CO DAK STREET ESTER, IN47394	ODE The state of t	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	at said res, other initiating confro- redirect."	res has not been ntation, unable to				
	other residents c stating they are used resident undirect behavior is unacleave the dining or quit making c 11/9/10 (no time comments to oth [Resident#39], used to him a "homo" are in the head becasstaff redirection continues louder room during measurements [Resident #39] a continues."	or cont [continues] [with] er resident ndirectable." or a.m., "resident very [Resident #39] calling and saying res needs "shot case he is so ugly" upon ares does not stop, just and time, removed and bad mouthing or a.m "Res conts to anents to [Resident #39], ", "ugly" tells him he's				
	_	n and make rude remarks] calling res a "homo"				

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155231	A. BUI		00	04/06/20	
		100201	B. WIN		A DDDEGG CITY CTATE 7ID CODE	04/00/20	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HOM	1E			ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	so ugly he needs to be					
		move, redirect from					
	_	plained several x's					
	[[times] that bena	avior is unacceptable"					
	11/13/10 at 3:00	p.m. "conts @ meals to					
	make rude comm						
	[Resident#39]"						
	11/17/10 at 9:00	a.m. resident continues					
	to be disrespectfu	al at mealtime to res					
	[Resident #39] st	ating "you are an ugly					
	homo, I should b	low your head off" when					
	trying to redirect	res to stop being rude					
	and disruptive re	s states "I know my					
	rights" unable to	redirect or get to remove					
	self from table'						
	11/25/10 at 9:30	a.m., "Resident very					
		[Resident #45]" in					
	1	a.m. for breakfast yelling					
	_	445] to "sit down stupid if					
	_	n being you could					
	comprehend"						
		m. "Resident conts to be					
	I	with] other residents					
	during breakfast,	calling them "ugly""					
	12/3/10 at 1:00 p	.m. "Resident continues					
	_	de to other residents					
		ect res gets louder and					
	I -	other residents "homo,					
	· ·	t, says they need to be					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		•	701 S C	DDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	shot in the head	"					
	`) "conts [with] verbal her res, redirection					
	and rudeness tov "homo" "ugly" s) "conts [with] behaviors wards other res calling res tates needs to be shot", [with] middle finger, eccessful"					
		p.m. "continues to make d yell to another resident					
	shift report CN to DR tablemate was holding classified to the cheek, write nurse tried to a from the table and was cursing "I'm not going rights, res there pushed writer, offering to tak he could finish	NA summoned writer ate [Resident #29] heek stated that had smacked her on ter and on coming remove [Resident #E] when res stood up and yelling stating anywhere, I have my a hit other nurse and upon redirection e res tray to room so and there res r, finally removed					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED
	PROVIDER OR SUPPLIER		 STREET A	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	from DR and clinical record Administrator physician was was placed on monitor behave transferred to psychiatric um 12/21/10. The the facility or .3) During an interversal above by Resident asked to provide do interventions the fathe verbal abuse incidents was athat were completed verbal abuse documercord. During an interview 4/4/11 at 5:30 p.m. no information to pabuse incidents con on the dates and timindicated the nurses abuse incidents in the report the incidents indicated she was nabuse incidents with the incidents	taken to room." The lindicated the and the resident's called. The resident 15 minute checks to vior. The resident was an inpatient it at 8:30 p.m. on e resident returned to 12/28/10. The resident returned to 12/28/10. The administrator on additional information was the reporting to the state ents of verbal abuse noted #E. The Administrator was	IAU			DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION 00	COMPL	ETED
		155231	B. WING			04/06/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RANDOL	PH NURSING HOM	ΛE			PAK STREET ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		e Administrator indicated she	+	TAG	DEFICIENCI)		DATE
		of the verbal abuse incidents					
	to the state agency.	of the versus assure meracines					
	2 ,						
	3.1-27(a)(1)						
F0225	The facility must n	not employ individuals who					
		guilty of abusing, neglecting,					
	•	dents by a court of law; or					
		g entered into the State y concerning abuse,					
		nent of residents or					
	_	of their property; and report					
		nas of actions by a court of					
	_	ployee, which would					
		for service as a nurse aide aff to the State nurse aide					
	registry or licensing						
	o ,						
	-	ensure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source tion of resident property are					
		tely to the administrator of					
	•	other officials in accordance					
	with State law thro						
	procedures (included certification agence)	ding to the State survey and					
	certification agenc	,y).					
	The facility must h	nave evidence that all					
		are thoroughly investigated,					
		further potential abuse					
	wrille trie investiga	ation is in progress.					
	The results of all i	nvestigations must be					
	reported to the ad						
	•	entative and to other					
		ance with State law					
	(including to the S	tate survey and certification					

	II 155021	A. BUIL	DING	00	COMPL 04/06/2	
	155231	B. WING			04/06/20	UTT
NAME OF PROVIDER OR SUPPLE			701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET IESTER, IN47394		
PREFIX (EACH DEFICI TAG REGULATORY)	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
and if the allege appropriate corn A. Based on rethe facility fail implement a fathiring employed within the last employee files #1), and failed resident verbal Administrator, of verbal abuse to report incide appropriate state ensure interver prevent further for 2 of 2 reside on the secured subjected to versident from #29) which we resident review abuse in a same B. Based on reconfacility failed to exhired by the facility residents had not		F02	225	F 225 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admiss or agreement by Randolph Nursing Home of the facts alleged or conclusions set fort this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fed laws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. This facility has policy and procedures in place to promot the resident right to be free from abuse and for pre-hire screening of applicants. Corrective action for affected residents Employed C.N.A #1 has been terminated (Attachment K) Residents #35 #45 were interviewed and their records reviewed for psychosomoutcomes of verbal abuse (without findings), Residents #35 #45 physicians and families were notified of the verbal abuse, a report was sent to Indiana State Department of Health.Resident #E was place on One-to-One supervision unfurther notice. All staff have be re-inserviced regarding recognition, intervention and reporting incidents of alleged	h in eral of n eming ee l. 9 & r ocial	04/22/2011

A BUILDING B. WING NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 1.) Review of the current undated facility policy, titled "Incidents of Alleged Abuse", provided by the administrator on 4/4/11 at 9:15 a.m., indicated the following, " Purpose: To ensure that each resident is free of physical, mental, verbal and sexual abuse, corporal punishment, mental and physical neglect, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or
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or volunteers, staff of other agencies serving the resident, family members or residents at risk; All employee files have been reviewed to
serving the resident, family members or files have been reviewed to
legal guardians, friends of other
individuals.
within the last 5years. see
Policy: (Attachment L) All staff have been
re-inserviced regarding
Residents residing in this facility will be recognition, intervention and
treated with dignity and respect in reporting incidents of alleged abuse. (Attachment C)Social
accordance with their individual needs. Service Director was re-educated
They will not be subjected to physical, to the Policies and Procedure's of
Rehavior Mot see (Attachment C)
mental, verbal and sexual abuse, corporal including identifying a resident's
punishment, mental and physical neglect, problem behavior including but
and involuntary seclusion. not limited to Physical and/or
verbal aggression. Identify
"Abuse" is the willful infliction of injury, precipitants to behavior including People involved, Environment,
unreasonable confinement, intimidation, Verbal and Non-Verbal Behavior
or punishment with resulting physical and using a Log to track
harm or pain or mental anguish, or behaviors and precipitating

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE deprivation by an individual, including a factors, and educate staff in manner's of approaching caretaker, of goods or services that are residents and appropriate necessary to attain or maintain physical, documentation on the resident's mental, and psychosocial well being. This Care Plan.Resident #E's chart was fully reviewed to ensure no presumes that instances of abuse of all more verbal and/or physical residents, even those in a coma, cause abuse had occurred. Measures to physical harm, or pain or mental anguish. ensure this deficient practice does not recur; Employee files Physical Abuse: have been reviewed to ensure all employees that have been hired have not been convicted of a Includes, but is not limited to, hitting, felony conviction within the last slapping, punching, kicking, etc. It also 5years. (Attachment L) April 22, includes controlling behavior through 2011 All staff have been re-inserviced regarding corporal punishment. recognition, intervention and reporting incidents of alleged Verbal Abuse: abuse. (Attachment C)Social Service Director was re-educated to the Policies and Procedure's of Refers to any use of oral, written, or Behavior Mgt, see (Attachment C) gestured language that includes including identifying a resident's disparaging and derogatory terms to problem behavior including but residents or their families, or within not limited to Physical and/or verbal aggression. Identify hearing distance, to describe residents precipitants to behavior including regardless of their age, ability to People involved, Environment, comprehend or disability. Examples of Verbal and Non-Verbal Behavior verbal abuse include, but are not limited and using a Log to track behaviors and precipitating to, threats of harm, saying things to factors, and educate staff in frighten a resident, such as telling a manner's of approaching resident that he/she will never be able to residents and appropriate see his/her family again.... documentation on the resident's Care Plan. April 6, 2011 Resident #E was placed on one-to-one Mental Abuse: monitoring until further notice.Resident #E's chart was Includes, but is not limited to, fully reviewed to ensure no more verbal and/or physical abuse had humiliation, harassment, threats of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ11

Facility ID:

000136

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 04/06/2011		
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			B. WING 04/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK STREET WINCHESTER, IN47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	mental abuse are physical abuse Procedure: Should any type occur, the follow followed: 1. Any staff mentincident of physis sexual abuse, muresident. 2. After the resident ensured, the staff report the incident charge of the factincident. (If admitsuilding at the time will be notified in in charge.) 3. A thorough invite allegations to information and staff. 4. There must be	of abuse or alleged abuse ing procedure is to be aber witnessing an cal, verbal, mental or est intervene on behalf of ent's immediate safety is member must then in to the staff member in illity at the time of the ministrator is not in the me of the incident, he/she mediately by the person vestigation is intimated of agather pertinent verify the occurrence. appropriate steps taken in (potential) abuse while			occurred. All Charts were reviewed to ensure behaviors physical and/or verbally aggression or socially inappropriate or disruptive behaviors have been appropriately addressed. (attachment I) Monitoring of corrective action; All employe files have been reviewed to ensure all employees that hav been hired have not been convicted of a felony convictio within the last 5years. see (Attachment L). Facility administrator will assure persount a felony conviction are reviewed and decline employment per Pre-Employm Screening Policy. The Bookkeeper or her designee was form (Attachment L) for all new hires, 5x weekly for 30 days, 1x weekly for 30 days, 1x weekly for 30 days, 1x weekly basis. Social Services Director was re-educated to Policies and Procedure's of Behavior Mgt, including identifying a resident's problem behavior including but not limit to Physical and/or verbal aggression. Identify precipitar to behavior including People involved, Environment, Verbal and Non-Verbal Behavior and using a Log to track behaviors and precipitating factors, and educate staff in manners of approaching residents. Lastly document these findings on the	e e n ons nent vill l ays, kly will n on e m ted	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155231	B. WIN			04/06/2	011
NAME OF S	DROLLIDED OD GLIDDLIEF	\		STREET A	ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF	PROVIDER OR SUPPLIEF	C		701 S C	DAK STREET		
RANDOLPH NURSING HOME					IESTER, IN47394		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG		A II	DATE
		l record for resident #E			Plan of Care. (Attachment C) A Charts have been reviewed to		
	was reviewed on	1 4/3/11 at 4:30 p.m.			ensure behaviors of physical		
					and/or verbally aggressive or		
	Resident #E's cu	rrent diagnoses included,			socially inappropriate or disru	otive	
	but were not lim	ited to, Huntington's			behaviors are recognized and		
	disease, mood di	sorder and dementia with			responded to appropriately.		
	agitation.				(Attachment I). Social Service Director reported findings of the		
	~				audit to the Administrator and	ii3	
	Resident #E had	a current healthcare plan,			QA/A committee. The Social		
		1 4/26/10, and was			Service Director or her design	ee	
		· · · · · · · · · · · · · · · · · · ·			will use form (Attachment I) fo		
	updated 1/12/11, which indicated the resident had a problem listed as, resident				monitoring 5x weekly for 30 da		
	1	· ·			3x weekly for 30 days, 1x weekly for 90 days in total. Findings v	-	
	1	becoming abusive to			be reported to the Administrate		
	others.				as well as to the QA&A comm		
	1	this problem included,			weekly.Facility administrator v		
		naviors, interventions			assure persons with a felony		
	1	idents response to			conviction are reviewed and		
	interventions use	ed.			decline employment per Pre-Employment Screening		
					Policy. Employees with a felo	nv	
	Nursing note ent	ries from Resident #E's			conviction within the past five	,	
	clinical record in	ndicated the following,			years are ineligible for hire.		
		-			Findings will be reported to the		
	10/29/10 at 5:00	p.m., "resident has been			QA&A team at least quarterly,	and	
	1	other residents at table			will become part of Randolph Nursing Homes Quality Assurance	20	
	1 '' '	n tried to redirect resident			Program.		
		very hateful cursing at			110giuii.		
		leave dining room when					
	1	_					
	finished instead continued to talk bad to tablemate. Social service made aware."						
	laviemate. Socia	ai scivice iliaut await.					
	10/30/10 at 3:00	p.m., " Resident has been					
		g other residents at DR					
	1	ble, saying "you're so					
	1	ot you", attempted to					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
155231		A. BUILDING B. WING		04/06/2011				
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	redirect resident. behaviors."	continues [with]						
	behaviors when of called other reside worthless, other is back, attempted to [without] success 11/1/10 at 10:00 other res [resider [breakfast], unableave DR, calling [homosexual], stablead, "ugly"." 11/6/10 at 2:00 p [continues] [with calls tablemate going to shoot you man, other reside comments." 11/7/10 at 6 p.m. [continued] beha called other reside called other reside at said res, other initiating confror redirect."	a.m.,"very rude to nt] during bkfst le to redirect, refused to g other res "homo ates res needs shot in .m., " Resident conts l] behaviors during meals ugly and states "they are ou" called him a macho ent did not respond to , "Res has had cont viors at meal [times] ugly - states he needs a er res - also tries to s to throw spill proof cup res has not been ntation, unable to						
	11/8/10 at 1:00 p	.m.,"cont to be rude to						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155231	A. BUILDING B. WING			04/06/2011	
NAME OF I	PROVIDER OR SUPPLIER		D. (VII.)		ADDRESS, CITY, STATE, ZIP CODE		
					DAK STREET		
RANDOLPH NURSING HOME				WINCH	ESTER, IN47394		
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	other residents ca	alling them "homos"					
	stating they are u	gly and need to be shot,					
		able, explained to res that					
		ceptable and he needs to					
	_	room, res refuses to leave					
	or quit making co	omments"					
	 11/9/10 (no time`) "cont [continues] [with]					
	comments to oth						
	[Resident#39], u	ndirectable."					
		a.m., "resident very					
		[Resident #39] calling					
		d saying res needs "shot					
		use he is so ugly" upon res does not stop, just					
		. Happens in dining					
	room during mea						
	[Resident #39] ar						
	continues."						
		0 a.m " Res conts to					
		nents to [Resident #39],					
		', "ugly" tells him he's					
	not getting nothing	п <u>у</u>					
	11/12/10 at 8:00	a.m." Resident conts to					
	sit in dining roon	n and make rude remarks					
	to [Resident #39]	calling res a "homo"					
		so ugly he needs to be					
		move, redirect from					
	_	plained several x's					
	[[times] that beha	avior is unacceptable"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S	ETED	
		155231	B. WIN			04/06/2	011
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME				701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΤE	(X5) COMPLETION
PREFIX TAG	REGULATORY OR 11/13/10 at 3:00 make rude comm [Resident#39]" 11/17/10 at 9:00 to be disrespectfu [Resident #39] st homo, I should b trying to redirect and disruptive re- rights" unable to self from table' 11/25/10 at 9:30 hateful [with] res- dining room this at res [Resident # you were a huma comprehend" 11/30/10 8:00 a.r verbally hateful [during breakfast, 12/3/10 at 1:00 p to be verbally rud when try to redire more verbal, call ugly and ignoran shot in the head .	p.m. "conts @ meals to tents to resident a.m. resident continues all at mealtime to resident a.m. resident continues all at mealtime to resident "you are an ugly low your head off" when res to stop being rude as states "I know my redirect or get to remove a.m., "Resident very [Resident #45]" in a.m. for breakfast yelling [#45] to "sit down stupid if a being you could m. "Resident conts to be [with] other residents calling them "ugly"" .m. "Resident continues de to other residents ect res gets louder and other residents "homo, t, says they need to be"		PREFIX TAG		TE	COMPLETION DATE
	· · ·) "conts [with] verbal her res, redirection					

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AND PLAN OF CORRECTION IDENTIFICATION NUM		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155231	B. WIN	G		04/06/2	2011	
	NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			701 S O	DDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394	-		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE .	COMPLETION	
TAG				TAG	DEFICIENCY)	NAIE	DATE	
	and rudeness tow "homo" "ugly" st flips said res off redirection unsuc 12/11/10 at 2:00 rude gestures and at meal time" 12/21/10 at 6 shift report CN to DR tablema was holding cl [Resident #E] the cheek, write nurse tried to refrom the table and was cursir "I'm not going rights, res there pushed writer, offering to tak he could finish punched write from DR and te clinical record Administrator	p.m. "continues to make d yell to another resident ::00 p.m., "during NA summoned writer ate [Resident #29] heek stated that had smacked her on ter and on coming remove [Resident #E] when res stood up and yelling stating anywhere, I have my hit other nurse and upon redirection e res tray to room so and there res r, finally removed taken to room." The						

l i		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155231	A. BUILDING B. WING			04/06/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	DAK STREET		
RANDOLPH NURSING HOME				WINCH	ESTER, IN47394		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATED DEFICIENCY)	E COMPLE' DATE	
1/10		15 minute checks to		mo		DATE	
	•	ior. The resident was					
	transferred to a						
		it at 8:30 p.m. on					
		e resident returned to					
	the facility on						
	_						
		rview with the Administrator madditional information was					
		the reporting to the state					
	*	ents of verbal abuse noted					
	•	E. The Administrator was					
	asked to provide do	cumentation of any cility implemented following					
		idents that were taken to					
		lents from reoccurring. The					
		sked for any investigations					
	-	following the incidents of					
	record.	ented in Resident #E's clinical					
ı							
		with the Administrator on she indicated the facility had					
		rovide related to the verbal					
		mitted by Resident #E noted					
	on the dates and tim	es above. The Administrator					
		who documented the verbal					
		ne clinical record failed to to anyone. She further					
		ot anyone. She further of any of the verbal				[
		Resident #E. She indicated					
	-	nvestigated any of the verbal					
		e Administrator indicated she					
	to the state agency.	of the verbal abuse incidents					
	· ·	current undated facility policy,					
	uuea Criminai Bac	kground Checks", provided by					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/06/2011	
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394	
	FIT NORSING FION	/IE		E31EK, IN47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	the Administrator or the following,	n 4/5/11 at 1:30 p.m., indicated			
	Criminal History Intibusiness days from a nurse aide or other I of the person's state the department and a Indiana Central Rep information" B2.) Review of the a 3:45 p.m. indicated by the facility on 1/1 The "Indiana State F History" report for 1/24/11 indicated the "Arrest I 01/13/20 Arrest Detail: Agency: [Name of Original Charge: Fra Original Charge: The Class / Level: D Fe Original Charge: The Class / Level: D Fe Amended Charge: The Class / Level: D Fe Amended Charge: The Class / Level: D Fe Amended Charge: The Class / Level: D Fe Original Charge: The Cla	Police Limited Criminal Employee CNA #1, dated e following, 09 County Sheriff Department] aud eft lony rgery Detail: mber Listed] lony Theft ony			
	Sentence: 18 M [mo	onths]			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/06/2011
	PROVIDER OR SUPPLIER		701 S (ADDRESS, CITY, STATE, ZIP CODE DAK STREET IESTER, IN47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=G	4/5/11 at 4:15 p.m. s no policy related to based on results of t Criminal History" ir indicated she was un been convicted of a 3.1-27(a)(1) The facility must of written policies an mistreatment, neg and misappropriat Based on record facility failed to policy related to for 2 of 2 resider on the secured do subjected to verb 39, 45) which w resident reviewer sample of 16. (R protect 1 of 1 res abuse (resident # committed by 1 for verbal and ph of 16. (Resident a and the facility	levelop and implement d procedures that prohibit elect, and abuse of residents from of resident property. The review and interview the follow the facility abuse incidents of verbal abuse ents reviewed who resided ementia unit who were had abuse (Resident #'S here committed by 1 of 1 d for verbal abuse in a resident #E) and failed to hident from physical electrons abuse in a sample of 1 resident reviewed has a sample	F0226	F 226 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admiss or agreement by Randolph Nursing Home of the facts alleged or conclusions set fort this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fed laws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. This s facility has policies prohibiting resident abuse including screening of applica	eral of

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li ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155231	B. WIN			04/06/2	011
NAME OF	DD OLUDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	C		701 S C	DAK STREET		
	_PH NURSING HON				IESTER, IN47394		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1 0 1 1	s with a felony conviction			through assuring appropriate	~	
	with in the last 5	years for 1 of 5			government regulated licensin reference checks and criminal		
	employee files re	eviewed. (Employee CNA			background check. Corrective		
	#1)				action for affected	_	
	,				residents Employee C.N.A #1	has	
	Findings include	.•			been terminated. (Attachment		
	1 manigs merade	·•			Residents #39 & #45 were		
	1) David Cut				interviewed and their records		
	1 '	ne current undated facility			reviewed for psychosocial		
	1 * * * * * * * * * * * * * * * * * * *	cidents of Alleged Abuse"			outcomes of verbal abuse (without findings), Residents #	120	
		e administrator on 4/4/11			& #45 physicians and families		
	at 9:15 a.m., ind	icated the following,			were notified of the verbal		
					abuse, a report was sent to		
	" Purpose:				Indiana State Department of		
	1				Health. Resident #E was place	ed	
	To ensure that es	ach resident is free of			on One-to-One supervision un		
					further notice. All staff have be	een	
		, verbal and sexual abuse,			re-inserviced by regarding		
		nent, mental and physical			recognition, intervention and reporting incidents of alleged		
	•	oluntary seclusion.			abuse. (Attachment C)Social		
	Residents must r	not be subjected to abuse			Service Director was re-educa	ited	
	by anyone include	ding, but not limited to,			April 20, 2011 to policy and		
	facility staff, oth	er residents, consultants			procedure of Behavior Mgt, se	e	
	or volunteers, sta	aff of other agencies			(Attachment C) including		
	serving the resid	ent, family members or			identifying a resident's probler		
	legal guardians,	•			behavior including but not limito Physical and/or verbal	iea	
	individuals.	The of one			aggressive. Identify precipitar	nte	
	individuals.				to behavior including People		
	D.D.				involved, Environment, Verbal		
	Policy:				and Non-Verbal Behavior and		
					using a log to track behaviors		
		ng in this facility will be			precipitating factors, and educ		
		nity and respect in			staff in manner of approaching	9	
	accordance with	their individual needs.			resident. Document these findings on the Care		
	They will not be	subjected to physical,			Plan. <u>Identification of other</u>		
	1 -	nd sexual abuse, corporal			residents at risk; All employee		
		ntal and physical neglect,			files have been reviewed to		
	I Pumsimiem, mei	mar and physical neglect,			<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE and involuntary seclusion. ensure all employees that have been hired have not been convicted of a felony conviction "Abuse" is the willful infliction of injury, within the last 5years. see unreasonable confinement, intimidation, (Attachment L) All staff have been re-inserviced regarding Incidents or punishment with resulting physical of Alleged Abuse. see harm or pain or mental anguish, or (Attachment C)Social Service deprivation by an individual, including a Director was re-educated to the caretaker, of goods or services that are Policies and Procedure's of necessary to attain or maintain physical, Behavior Mgt. see (Attachment C) including identifying a resident's mental, and psychosocial well being. This problem behavior including but presumes that instances of abuse of all not limited to Physical and/or residents, even those in a coma, cause verbal aggression. Identify physical harm, or pain or mental anguish. precipitants to behavior including People involved, Environment, Verbal and Non-Verbal Behavior Physical Abuse: and using a Log to track behaviors and precipitating factors, and educate staff in Includes, but is not limited to, hitting, manner's of approaching slapping, punching, kicking, etc. It also residents and appropriate includes controlling behavior through documentation on the resident's corporal punishment. Care Plan.Resident #E's chart was fully reviewed by the facility administrator and Director of Verbal Abuse: Operations April 5, 2011 for identification of occurrence of, or Refers to any use of oral, written, or residents potentially affected by. gestured language that includes verbal and/or physical abuse. Measures to ensure this disparaging and derogatory terms to deficient practice does not residents or their families, or within recur; Employee files have been hearing distance, to describe residents reviewed to ensure all employees regardless of their age, ability to that have been hired have not been convicted of a felony comprehend or disability. Examples of conviction within the last 5years. verbal abuse include, but are not limited (Attachment L) April 19, 2011 All to, threats of harm, saying things to staff have been re-inserviced frighten a resident, such as telling a regarding Incidents of Alleged Abuse. (Attachment C)Social resident that he/she will never be able to

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		NSTRUCTION 00	(X3) DATE S COMPLI	ETED	
		155231	B. WING			04/06/20	011
	PROVIDER OR SUPPLIEI			701 S O	DDRESS, CITY, STATE, ZIP CODE AK STREET ESTER, IN47394	!	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	P.	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS, DEFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	see his/her famil Mental Abuse: Includes, but is a humiliation, hara punishment or d procedures for remental abuse are physical abuse Procedure: Should any type occur, the follow followed: 1. Any staff mer incident of phys sexual abuse, mare incident. 2. After the residence ensured, the staff report the incide charge of the face.	y again not limited to, assment, threats of eprivation. The eporting and documenting the same as reporting	P		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ated int ints ints ints ints ints ints ints	
		me of the incident, he/she mmediately by the person			files have been reviewed to ensure all employees that hav been hired have not been		
	3. A thorough in the allegations to	vestigation is intimated of gather pertinent verify the occurrence.			convicted of a felony conviction within the last 5 years. see (Attachment L) The Bookkeep or her designee will use form (Attachment L) for all new hire	er	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155231	A. BUI	LDING	00	COMPL 04/06/2	
		199231	B. WIN			04/00/2	011
NAME OF	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
DANIDOI	LPH NURSING HO	AF		1	DAK STREET ESTER, IN47394		
					E31EN, IN47394		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
		,	- 		5x weekly for 30 days, 3x wee	klv	
	1 There must be	e appropriate steps taken			for 30 days, 1x weekly for 90 d		
		er (potential) abuse while			in total. Findings will be report		
	1 ^	•			to the QA&A team on a weekly		
	the investigation	is in progress"			basis. The Social Service Dire or her designee will monitor	ctor	
	2) The distant				resident behaviors (Attachmer	nt I)	
	1 ′	record for resident #E was			5x weekly for 30 days, 3x wee		
	reviewed on 4/3/	711 at 4:30 p.m.			for 30 days, 1x weekly for 90 of in total. Findings will be report	•	
	Resident #E's cu	rrent diagnoses included,			to the Administrator as well as		
	1	ited to, Huntington's			the QA&A committee		
	1	isorder and dementia with			weekly.Facility administrator wassure persons with a felony	/ill	
	agitation.				conviction are reviewed are hi	red	
					or decline employment per		
					Pre-Employment Screening		
	Nursing note ent	tries from Resident #E's			Policy. Employees with a felo	ny	
	1 -	ndicated the following,			conviction within the past five years are ineligible for hire.		
		2,			Findings will be reported to the	•	
	10/29/10 at 5:00	p.m., "resident has been			QA&A team at least quarterly,		
	1	other residents at table			will become part of Randolph		
	1	n tried to redirect resident			Nursing Homes Quality Assurance	ee	
		very hateful cursing at			Program.		
	1	leave dining room when					
	1	continued to talk bad to					
		al service made aware."					
		· · · · · · · · · · · · · · · · · · ·					
	10/30/10 at 3:00	p.m., " Resident has been					
	verbally taunting	g other residents at DR					
	[dining room] ta	ble, saying "you're so					
	ugly, I'd just sho	ot you", attempted to					
	redirect resident	continues [with]					
	behaviors."						
	10/31/10, at 3:00	p.m. "Continues [with]					
	behaviors when	@ [at] table in DR.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CO			(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155231	А. Е	BUILDING	00		04/06/2	
		100201	B. V	VING			04/06/2	UII
NAME OF I	PROVIDER OR SUPPLIER	2			DDRESS, CITY, STA	TE, ZIP CODE		
DVNDOI	PH NURSING HON	ΛΕ		I	AK STREET ESTER, IN47394	4		
					ESTER, IN4739	1 		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION E ACTION SHOULD BE		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	ED TO THE APPROPRIAT	E	COMPLETION DATE
IAG		dent gay, ugly and	-	IAG				DAIL
		resident did not respond						
	· ·	•						
	_	to redirect resident						
	[without] success	S.						
	11/1/10 -4 10.00							
		a.m.,"very rude to						
	other res [resider							
		ole to redirect, refused to						
		g other res "homo						
	-	ates res needs shot in						
	head, "ugly"."							
	11/6/10 . 2 00	H.D. 11						
	1	o.m., " Resident conts						
		n] behaviors during meals						
		ugly and states "they are						
		ou" called him a macho						
		ent did not respond to						
	comments."							
	1	., "Res has had cont						
	-	viors at meal [times]						
		igly - states he needs a						
	~	er res - also tries to						
	1 *	s to throw spill proof cup						
	at said res, other							
		ntation, unable to						
	redirect."							
	11/8/10 at 1:00 p	o.m.,"cont to be rude to						
	other residents ca	alling them "homos"						
	stating they are u	igly and need to be shot,						
	resident undirect	able, explained to res that						
	behavior is unac	ceptable and he needs to						
		room, res refuses to leave						
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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION 00	CC	ATE SURVEY OMPLETED O6/2011
	PROVIDER OR SUPPLIER		STRI 701	EET ADDRESS, CITY, ST S OAK STREET NCHESTER, IN4739		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI	X (EACH CORRECTI CROSS-REFERENC	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIATE SPICIENCY)	(X5) COMPLETION DATE
	or quit making co	omments"				
	11/9/10 (no time) comments to othe [Resident#39], un 11/10/10 at 10:00 verbally rude to [him a "homo" an in the head becaustaff redirection recontinues louder room during mea [Resident #39] are continues." 11/11/10 at 10:0 make rude commencalls him "homo" not getting nothin 11/12/10 at 8:00 sit in dining room to [Resident #39] and saying res is shot unable to redining room. Ex [times] that behalter to the commence of the comm	"cont [continues] [with] er resident ndirectable." "a.m., "resident very [Resident #39] calling d saying res needs "shot use he is so ugly" upon res does not stop, just happens in dining all time, removed and bad mouthing "a.m" Resident #39], ", "ugly" tells him he's ng" "a.m." Resident conts to an and make rude remarks calling res a "homo" so ugly he needs to be move, redirect from plained several x's avior is unacceptable" "p.m. "conts @ meals to needs to resident				
	11/17/10 at 9:00	a.m. resident continues				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIER			701 S O	DDRESS, CITY, STATE, ZIP CODE DAK STREET		
RANDOL	.PH NURSING HON	ЛΕ		WINCH	ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE.	(X5) COMPLETION DATE
	[Resident #39] s homo, I should be trying to redirect and disruptive re rights" unable to self from table						
	hateful [with] red dining room this at res [Resident a	a.m., "Resident very s [Resident #45]" in a.m. for breakfast yelling #45] to "sit down stupid if an being you could					
	verbally hateful	m. "Resident conts to be [with] other residents calling them "ugly""					
	to be verbally ru when try to redir more verbal, call	o.m. "Resident continues de to other residents ect res gets louder and other residents "homo, at, says they need to be "					
	`) "conts [with] verbal her res, redirection					
	and rudeness tov "homo" "ugly" s) "conts [with] behaviors vards other res calling res tates needs to be shot", [with] middle finger,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155231	B. WING			04/06/2	011
NAME OF I	PROVIDER OR SUPPLIER		I		DDRESS, CITY, STATE, ZIP CODE		
RANDOL	PH NURSING HOM	Λ F	I		OAK STREET ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID	1			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	ì	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	redirection unsuc	ccessful"		Ī			
		p.m. "continues to make					
	_	d yell to another resident					
	at meal time"						
	2) During on int	arrian with the					
	3.) During an into	erview with the 14/3/11 at 6:45 p.m.					
		nation was requested					
		orting to the state agency					
	1	of verbal abuse noted					
		nt #E. The Administrator					
	I -	vide documentation of					
	any interventions						
	l -	lowing the verbal abuse					
	incidents that we	re taken to prevent					
	further incidents	from reoccurring. The					
	Administrator wa	as asked for any					
	_	at were completed					
		eidents of verbal abuse					
		Resident #E's clinical					
	record.						
	During on inter-	ion with the					
	During an intervi	14/4/11 at 5:30 p.m. she					
		ility had no information					
		d to the verbal abuse					
	_	tted by Resident #E noted					
		times above. The					
		dicated the facility did					
		buse policy. She					
		rses who documented the					
	verbal abuse inci	dents in the clinical					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231			ULTIPLE CO LDING	NSTRUCTION 00	CO	ATE SURVEY MPLETED 16/2011	
		155251	B. WIN				0/2011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CO DAK STREET	DDE	
RANDOL	PH NURSING HOM	ΛE			ESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF	PECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		eport the incidents to the indicated she was not					
	•	he verbal abuse incidents					
	"	E. She indicated the					
		nvestigated any of the					
	verbal abuse inci	dents. The Administrator					
		I not reported any of the					
	verbal abuse inci	dents to the state agency.					
	1) Pavious of the	e current undated facility					
	l ′	iminal Background					
	1 * * * *	ed by the Administrator					
		p.m., indicated the					
	following,	1					
	_ ^	lete the "Request for					
		l History Information"					
		ousiness days from date a red as a nurse aide or					
		aployee for a copy of the					
		rse aide registry report					
	1 ^	nent and a criminal					
	history from the						
	Repository for cr	riminal history					
	information"						
	5) David Col	1 £1					
	l '	e employee files on m. indicated Employee					
	1	ed by the facility on					
	1/13/11.	of the facility off					
	,,						
	The "Indiana Sta	te Police Limited					
	Criminal History	" report for Employee					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155231	A. BUI	LDING	00	COMPLE 04/06/20	
		100231	B. WIN			04/06/20	/11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
RANDOL	PH NURSING HOM	ΛF		1	DAK STREET ESTER, IN47394		
					LOTER, 11477004		77.0
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
-		/24/11 indicated the		_			
	following,	2 1/ 11 1110100000 0110					
	"Arrest 1 01/13/	/2009					
	Arrest Detail:						
		of County Sheriff					
	Department]	P. 1					
	Original Charge:						
	Original Charge:						
	Class / Level : D	•					
	Original Charge:	Forgery					
	Prosecutor / Cou	rt Detail:					
	Cause Number: [Number Listed]					
	Filed Charge: Th	eft					
	Class / Level : D	Felony					
	Amended Charge	e: Theft					
	Class / Level D	Felony					
	Disposition: Guil	lty					
	Sentence: 18 M [[months]					
	Probation: 18M	."					
	6.) During an into	erview with the					
	Administrator on	4/5/11 at 4:15 p.m. she					
	indicated the fac	eility had no policy					
	related to employ	ee hiring based on					
	results of the emp	ployee's "Limited					
	Criminal History	" information. She					
	further indicated	she was unaware					
	Employee CNA #	#1 had been convicted of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
	155231	B. WIN			04/06/2	011
		D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPL	IER			OAK STREET		
RANDOLPH NURSING H	OME		WINCH	ESTER, IN47394		
` '	Y STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
, i	ENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
a felony theft	charge.					
3.1-28(a)						
social services highest practica psychosocial w	of provide medically-related to attain or maintain the able physical, mental, and ell-being of each resident.					
Based on reconfacility failed reviewed and incidents of reto ensure incidinvestigated, interventions of prevent further for 2 of 2 residual subjected to votage, 45,), fail from physical were committed reviewed for (Resident #E), ensure the Socresidents with 3 residents reviewed from the facility sample of 16. Findings included.	ord review and interview the or ensure Social Services intervened following sident verbal abuse, failed tents of verbal abuse were failed to ensure were implemented to or incidents of verbal abuse tents reviewed who were erbal abuse (Resident #'S ed to protect 1 of 1 resident abuse (resident #29) which ed by 1 of 1 resident verbal and physical abuse and the facility failed to ial Services assisted discharge planning for 2 of iewed who were discharged ty (Resident #'s C, D) in a	F0	250	F 250 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admissi or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fedelaws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. This facility provides medically related social services to attair maintain the highest practicable physical, mental, and psychosocial well being of eacresident. Corrective action for affected residents Previously discharged residents C and D residing at Parkview of Muncie Residents #39 and Resident #were interviewed and each was without recollection of the ever Both families and physicians wonotified of the subjected verbal	eral of of or e h are s. 45 s ont.	04/22/2011

li ´			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		155231	B. WIN	04/06/2011			
					ADDRESS, CITY, STATE, ZIP CODE	ļ.	
NAME OF F	PROVIDER OR SUPPLIER				OAK STREET		
RANDOL	PH NURSING HOM	ΛΕ		1	HESTER, IN47394		
					. ,	(M.5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	
IAG			+	IAG	abuse.On April 6, 2011 Reside		
		ded by the Administrator			#E was placed on one-to-one	, iii	
		p.m. indicated the			monitoring until further notice	The	
	following,				Social Service Director was		
					re-educated to Job Description	n	
	"Policy:				including responsibility for		
					planning, developing, organizi	ng,	
	The Social Service	ces Department will			implementing, evaluating and		
		referrals to provide			directing the Social Service		
	-	-			programs. Assess each residence and	ent	
	* * *	ventions and input to			s psychosocial needs and develop the plan of care. Ass	ist	
		ning a plan of treatment			with discharge planning,		
	for those resident	ts as needing "Behavior			development and implemental	tion	
	Management."				of the discharge plan. Social		
					Service Director was re-educa	ited	
					to policy and procedure of		
	Procedure: The	Social Services			Behavior Mgt, including		
	Department along				identifying a resident's probler		
	•	~			behavior including but not limit	tea	
	multidisciplinary	team wiii:			to physical and/or verbal aggression. Identify precipitar	nte	
					to behavior including people		
	1. Identify a resid	dent's problem behavior			involved, environment, verbal	and	
	(i.e. behavior tha	t may adversely affect the			non-verbal behavior and using	l l	
	well being of the	resident themselves,			log to track behaviors and		
	other residents, e	tc.) including, but not			precipitating factors, and educ		
	limited to:	,			staff in manner of approaching]	
					resident. As well as,		
	a Dhygiaally and	or verbally aggressive			documentation updating the resident's Care Plan. (Attachn	nent	
		or verbarry aggressive			C)Identification of other reside		
	(abusive)				at risk; Audit of discharged	····	
		ropriate or disruptive			resident records was complete	ed	
	behavior				ensuring placement for the		
					resident was found and		
	2. Identify precip	pitants to behavior,			appropriate communication to	l l	
	including, but no	t limited to:			responsible party. (Attachmer	nt I)	
	<i>S</i> ,				Resident and staff interviews were completed to determine		
	a. People involve	ed.			indication of other occurrences	s of	
	-	A. C.			potential verbal or physical		
	b. Environment				T POTOTION TOTAL OF PITYOROU	i i	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			Γ Γ			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155231	B. WIN			04/06/2011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				DAK STREET	
RANDOL	PH NURSING HOM	ΛF		1	IESTER, IN47394	
			_			1 770
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE
IAU		· · · · · · · · · · · · · · · · · · ·	+	IAG	abuse. Resident #E's chart w	
c. Verbal and non-verbal behavior				fully reviewed to identify poten	l l	
					occurrences of verbal and/or	
	Use the "Behavio	or Monitoring Log" to			physical abuse for further	
	track behaviors a	and precipitating factors			investigation and action as	
	and the "Evaluati	ion for New Or			indicated. Measures to ensure	<u>. </u>
	Worsening Behav	vioral Symptoms" to			this cited practice does not	
	ı	s resident behaviors.			recur; April 6, 2011 Resident #	ᄔ
					was placed on one-to-one	
	3 Describe the in	mpact of resident			monitoring until further notice. Social Service Director	.
	behavior on:	inpact of resident			was re-educated to policy and	l l
	Denavior on.				procedure of Behavior Mgt, se	
					(Attachment C) including	
		piting the problem			identifying a resident's probler	
	behavior				behavior including but not limit	ted
	b. Other resident	S			to Physical and/or verbal	
	c. Staff's ability t	o perform treatment for			aggression. Identify precipitar to behavior including People	11.5
	resident with pro	blem			involved, Environment, Verbal	
	_				and Non-Verbal Behavior and	
	4 Identify desire	d behavior or change/			using a log to track behaviors	and
	goals.				precipitating factors, and educ	
	gouis.				staff in manner of approaching	
	5. Establish inter				resident. Documentation of th	
	3. Establish liner	ventions			findings on the Care Plan.Soc Service Director was re-educa	
					to the Social Service Job	
		n manner of approaching			Description including discharg	ge
	resident				planning, development and	
	b. One - to -one v	•			implementation of the discharge	ge
	c. Mental health	evaluation / intervention			plan, assisting with resident	
	d. Behavior prog	rams			placement or relocation and notification of responsible part	v of
	-contracting				discharge plan. Monitoring of	y 01
	-rewarding				corrective action; On April 6,	
	-redirection				2011 Resident #E was placed	on
	-reinforcement				one-to-one monitoring until fur	
	1				notice and Social Services	
	-group support	den Grens muchlers			reviews the behavior log for	
		tion from problem			resident 5x weekly and reports	
	situation				behavior events to the IDT dur	"'Y

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231			LDING	NSTRUCTION 00	(X3) DATE (COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIE		p	STREET A	DAK STREET ESTER, IN47394		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PERCENTY OF THE PERC		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION
TAG	-family involver -monitoring side medications -pastoral interver 6. Document or a. Problems b. Goals c. Approaches 7. Establish met behavior logging a. Noted occurre b. Interventions c. Results" 2.) Review of the policy, titled "Joby the Administ p.m. indicated the Title: Social Se 1. Purpose The primary pure is to assist the produced policy and Services in accordance of the policy and Services of the policy an	e effects of psychotropic entions n Care Plan hod of staffs recording / g of: ence of problem behavior ne current undated facility ob Descriptions" ,provided rator on 4/5/11 at 1:30 ne following:		TAG	daily manager meeting. Finding will also be reported to the Q team on a weekly basis. (Attachment C) The Administrator is responsible at the facility abuse coordinator has ultimate oversight in the discharge process and review facility process and monitoring. The Social Service Director of designee will monitor behavior events to ensure physical and verbally aggressive or sociall inappropriate or disruptive behaviors have appropriate action. (Attachment I) Social Service Director will monitor discharges to assure appropriate action. (Attachment Social Service Director or designee will continue these monitors 5x weekly for 30 days, and weekly for 90 days in total. Findings will be reported to the QA&A team on a weekly bas and will become part of Randol Nursing Homes Quality Assurant Program.	ngs A&A as and v of g. or or d/or y riate I) ys, 3 d 1 x as	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231			(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	CO	MTE SURVEY MPLETED 6/2011
	PROVIDER OR SUPPLIER		D. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO DAK STREET ESTER, IN47394	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	facility, this posi- medically related needs of the resid on an individual						
	J	l Responsibilities					
	organizing, imple	or planning, developing, ementing, evaluating, and Social Service programs					
		esident's psychosocial op the plan for providing					
	development and	scharge planning, I implementation of the and if appropriate arrange esources"					
	3) .The clinical reviewed on 4/3/	ecord for resident #E was 11 at 4:30 p.m.					
	but were not limi	rrent diagnoses included, ited to, Huntington's sorder and dementia with					
	_	ries from Resident #E's dicated the following,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE SUR COMPLETI 04/06/201	ED	
		155231	B. WIN			04/06/201	I
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HON			1	ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re C	OMPLETION DATE
IAG			+	IAU			DATE
	10/29/10 at 5:00 p.m., "resident has been verbally [sic] to other residents at table						
	, ,	tried to redirect resident					
		very hateful cursing at					
		leave dining room when					
		continued to talk bad to					
		il service made aware."					
	10/30/10 at 3:00	p.m., " Resident has been					
	verbally taunting	other residents at DR					
	[dining room] tal	ole, saying "you're so					
	ugly, I'd just sho	ot you", attempted to					
	redirect resident.	continues [with]					
	behaviors."						
	10/31/10 at 3:00	p.m. "Continues [with]					
	-	(a) [at] table in DR.					
		lent gay, ugly and					
		resident did not respond					
		to redirect resident					
	[without] success						
	11/1/10 at 10:00	a.m.,"very rude to					
	other res [resider	nt] during bkfst					
	[breakfast], unab	le to redirect, refused to					
	_	g other res "homo					
		ates res needs shot in					
	head, "ugly"."						
	11/6/10 -4 2:00	II Danidand					
	_	.m., "Resident conts					
] behaviors during meals					
		ugly and states "they are					
		ou" called him a macho					
	man, other reside	ent did not respond to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ11

Facility ID:

000136

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY IPLETED 5/2011	
· · ·	PROVIDER OR SUPPLIER		701 S C	ADDRESS, CITY, STATE, ZIP DAK STREET IESTER, IN47394	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	[continued] behat called other resident undirect behavior is unactleave the dining or quit making comments to oth [Resident#39], until 11/10/10 at 10:00 verbally rude to him a "homo" ari in the head becaus taff redirection continues louder room during mea [Resident #39] a continues."	ntation, unable to o.m.,"cont to be rude to alling them "homos" agly and need to be shot, able, explained to res that ceptable and he needs to room, res refuses to leave omments") "cont [continues] [with] er resident ndirectable." O a.m., "resident very [Resident #39] calling ad saying res needs "shot use he is so ugly" upon res does not stop, just . Happens in dining				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 04/06	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER	ΛΕ	701 S C	DDRESS, CITY, STATE, ZIP C DAK STREET ESTER, IN47394	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		nents to [Resident #39], ", "ugly" tells him he's ng"				
	sit in dining room to [Resident #39] and saying res is shot unable to re dining room. Ex [times] that behat 11/13/10 at 3:00 make rude comm [Resident#39]" 11/17/10 at 9:00 to be disrespectful [Resident #39] shomo, I should be trying to redirect and disruptive re rights" unable to self from table 11/25/10 at 9:30 hateful [with] resident #39 at res [Resident #39]"					
		m. "Resident conts to be [with] other residents				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	!	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RANDOL	.PH NURSING HO	МЕ			OAK STREET ESTER, IN47394		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	·		(X5)
PREFIX	*	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	during breaktast	, calling them "ugly""					
	12/3/10 at 1:00 pto be verbally ruwhen try to redirmore verbal, callugly and ignorary shot in the head 12/6/10 (no time abuse towards of unsuccessful" 12/8/10 (no time and rudeness tow "homo" "ugly" sflips said res off redirection unsuccessful" 12/11/10 at 2:00 rude gestures and at meal time" 12/21/10 at 6 shift report CN to DR tablemate was holding continued to the cheek, writinurse tried to the cheek, writinurse tried to the continued to the cheek, writinurse tried to the cheek.	o.m. "Resident continues de to other residents rect res gets louder and dother residents "homo, at, says they need to be" E) "conts [with] verbal ther res, redirection E) "conts [with] behaviors wards other res calling restates needs to be shot", [with] middle finger, eccessful" p.m. "continues to make do yell to another resident E:00 p.m., "during NA summoned writer ate [Resident #29] heek stated that had smacked her on ter and on coming remove [Resident #E]					
		when res stood up					
	and was cursii	ng and yelling stating					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/06/2011	
	PROVIDER OR SUPPLIER		701 S (ADDRESS, CITY, STATE, ZIP CODE DAK STREET IESTER, IN47394	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	rights, res ther pushed writer, offering to tak he could finish punched write from DR and to clinical record Administrator physician was was placed on monitor behave transferred to a psychiatric un 12/21/10. The the facility on During an interview Designee on 4/5/11 was unaware of the above. She further any of the incidents She indicated she redaily and none of the verbal abuse commirecorded on a "Beha had made no interverse."	r, finally removed taken to room." The indicated the and the resident's called. The resident 15 minute checks to rior. The resident was an inpatient it at 8:30 p.m. on e resident returned to			
SS=G	reviewed on 4/4/ resident's diagno	s clinical record was 11 at 2:50 p.m. The ses included, but were sychosis; mood disorder;		F 250 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admiss	04/22/2011 sion

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE vascular dementia; deaf and mute. or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in The resident had a 3/2/11, telephone this statement of deficiencies. physician's order for Resident #D to be The plan of correction and specific corrective actions are sent out to the emergency room for prepared and/or executed in possible psychiatric placement. compliance with state and federal laws. Please accept this plan of Review of a 3/3/11, Social Services correction as our credible Progress Note indicated resident was allegation of compliance with all regulatory requirements. admitted to the psychiatric unit on 3/2/11. This facility provides medically related social services to attain or During an interview with the Discharge maintain the highest practicable Planner at an in-patient Geri-Psych Unit physical, mental, and psychosocial well being of each on 4/6/11 at 8:00 a.m., she indicated she resident. Corrective action for had updated the facility of Resident D's affected residents Previously progress during his stay on the unit. She discharged residents C and D are indicated she notified the facility the residing at Parkview of Muncie. Residents #39 and Resident #45 resident was stable and could return to the were interviewed and each was facility. She indicated the facility refused without recollection of the event. to readmit the resident and did not assist Both families and physicians were in finding a new placement for the notified of the subjected verbal resident. She indicated the resident's abuse.On April 6, 2011 Resident #E was placed on one-to-one family had not been given a 30 day notice monitoring until further notice The of discharge. Social Service Director was re-educated to Job Description including responsibility for During an interview with the planning, developing, organizing, Administrator and Social Service implementing, evaluating and Designee on 4/5/11 at 3:50 p.m., they directing the Social Service indicated they did not readmit the resident programs. Assess each resident' s psychosocial needs and to the facility due to not being able to develop the plan of care. Assist meet the resident's needs. They indicated with discharge planning, the resident had been out to a psychiatric development and implementation unit in February, 2011 and readmitted of the discharge plan. Social Service Director was re-educated after that stay. They indicated the resident

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ11

Facility ID:

000136

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155231 04/06/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 701 S OAK STREET RANDOLPH NURSING HOME WINCHESTER, IN47394 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to policy and procedure of would become aggressive without Behavior Mat. including provocation. The Social Service identifying a resident's problem Designee indicated the resident was not behavior including but not limited meeting his Care Plan Goal of "I will not to physical and/or verbal aggression. Identify precipitants hit other people, if I become angry I will to behavior including people remove myself from the situation that is involved, environment, verbal and upsetting me." They indicated there was non-verbal behavior and using a no documentation of a 30 day discharge log to track behaviors and notice being given to the family. precipitating factors, and educate staff in manner of approaching resident. As well as, During an interview with the resident's documentation updating the Power of Attorney on 4/6/11 at 8:20 a.m., resident's Care Plan. (Attachment she indicated she could not remember if C)Identification of other residents at risk; Audit of discharged she had been given a 30 day discharge resident records was completed notice or not. ensuring placement for the resident was found and appropriate communication to the 4. Resident #C's clinical record was responsible party. (Attachment I) reviewed on 4/4/11 at 12:50 p.m. The Resident and staff interviews resident's diagnoses included, but were were completed to determine not limited to, dementia with behavioral indication of other occurrences of disturbances, personality disorders, and potential verbal or physical abuse. Resident #E's chart was mood disorder. fully reviewed to identify potential occurrences of verbal and/or The resident had a 2/16/11, Physician's physical abuse for further order for the resident to be transferred to investigation and action as indicated. Measures to ensure the emergency room for a psychiatric this cited practice does not evaluation and treatment. recur; April 6, 2011 Resident #E was placed on one-to-one Review of a 2/16/11, Social Service monitoring until further notice. Social Service Director Progress note indicated the resident was re-educated to policy and transferred to an in-patient psychiatric procedure of Behavior Mgt, see unit due to an increase in unwarranted (Attachment C) including accusations towards staff members. identifying a resident's problem behavior including but not limited Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155231	B. WIN	IG		04/06/2011
NAME OF F	PROVIDER OR SUPPLIER		-	1	ADDRESS, CITY, STATE, ZIP CODE	
					DAK STREET	
RANDOL	PH NURSING HOM	1E		WINCH	IESTER, IN47394	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	iew with the Discharge			to Physical and/or verbal	
	Planner at an in-patient Geri-Psych Unit				aggression. Identify precipitar to behavior including People	its
	on 4/6/11 at 8:00	a.m., she indicated she			involved, Environment, Verbal	
	had updated the f	facility of Resident C's			and Non-Verbal Behavior and	
	-	ner stay on the unit. She			using a log to track behaviors	and
		tified the facility the			precipitating factors, and educ	
		le and could return to the			staff in manner of approaching	
		icated the facility refused			resident. Documentation of th	
	-				findings on the Care Plan.Soci Service Director was re-educa	
		sident and did not assist			to the Social Service Job	ieu
		placement for the			Description including discharg	e I I
	resident.				planning, development and	
					implementation of the discharg	je
	During an intervi	iew with the			plan, assisting with resident	
	Administrator an	d Social Service			placement or relocation and	,
	Designee on 4/5/	11 at 3:50 p.m., they			notification of responsible part discharge plan. Monitoring of	y ot
	_	d not readmit the resident			corrective action; On April 6,	
	-	e to not being able to			2011 Resident #E was placed	on I
	-	's needs. They indicated			one-to-one monitoring until fur	
		peen out to a psychiatric			notice and Social Services	
		r, 2010 and readmitted			reviews the behavior log for	
					resident 5x weekly and reports	
		hey indicated the resident			behavior events to the IDT dur daily manager meeting. Findin	· 1
		haviors of threatening the			will also be reported to the QA	- 1
	_	false accusations against			team on a weekly basis.	-
	the staff. They in	ndicated they had not			(Attachment C) The	
	given a 30 day di	ischarge notice to the			Administrator is responsible as	
	family.				the facility abuse coordinator a	ind
					has ultimate oversight in the discharge process and review	of
	This Federal tag	relates to complaint			facility process and monitoring	
	#IN00087993	•			The Social Service Director or	·
					designee will monitor behavior	
	3.1-34(a)				events to ensure physical and	
	3.1-3π(a)				verbally aggressive or socially	
					inappropriate or disruptive	
					behaviors have appropriate action. (Attachment I) Social	
					action. (Attacinnent I) Social	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155231			(X2) MULTIPLE CO A. BUILDING B. WING	00	` ′	e survey Pleted 2011
	PROVIDER OR SUPPLIER		STREET / 701 S (ADDRESS, CITY, STATE, ZIP CO DAK STREET IESTER, IN47394	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F0272	periodically a comstandardized representation and assessment of a representation and customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well-Physical functionin Continence; Disease diagnosis Dental and nutritic Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of regarding the additional communication	ke a comprehensive esident's needs, using the he State. The assessment ast the following: demographic information; e; e; or patterns; being; ng and structural problems; and health conditions; onal status;		Service Director will me discharges to assure a placement and family communication. (Attact Social Service Director designee will continue monitors 5x weekly for 30 day weekly for 90 days in the Findings will be reported QA&A team on a week and will become part of I Nursing Homes Quality A Program.	ppropriate hment I) r or these 30 days, 3 ys, and 1 x otal. ed to the ly basis, Randolph	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION		A. BUILDING 04/06/2011				
		155231	B. WIN			04/06/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
DANIDOL	DI LAUDOINO LION	A		1	DAK STREET		
RANDOL	.PH NURSING HOM	1E		WINCE	IESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	protocols; and Documentation of participation in assessment. Based on record review and						
SS=D			FO	272	F 272 Preparation and/or		04/22/2011
	interview, the	facility failed to			execution of this plan of correction in general, or this		
	ensure residen	ts identified at risk			corrective action in particular,		
	for constination	n were assessed by			does not constitute an admissi	ion	
	•	ff in accordance with			or agreement by Randolph Nursing Home of the facts		
	_				alleged or conclusions set forth	h in	
	their plan of ca				this statement of deficiencies.		
	administer phy	sician ordered			The plan of correction and		
	interventions v	when necessary to			specific corrective actions are prepared and/or executed in		
	prevent constit	pation for 2 of 11			compliance with state and fede	eral	
	residents revie	•			laws. Please accept this plan		
					correction as our credible		
	_	a sample of 16.			allegation of compliance with	า	
	(Resident #45	and #30)			all regulatory requirements.		
					Assessments are conducted for each resident including bowel	or	
	Findings inclu	de:			elimination. Corrective action for	or	
	C				affected residents Residents #		
	1) The elinion	al record for Resident			& # 30 have been assessed ar		
	<i>'</i>				care plans reviewed and revise		
	#45 was reviev	wed on 4/5/11 at 2:30			as needed to assure monitorin of bowel movements and	ig	
	p.m.				assessment and intervention a	as	
					indicated for the prevention of		
	Diagnoses for	Resident #45			constipation. Nursing educatio	n	
	_	vere not limited to,			was provided to reinforce the necessity of monitoring and		
	Í .	· ·			following the resident's care pl	an	
	Aizneimer's di	sease with delusions.			for promoting bowel function a		
					preventing constipation.		
	A Significant (Change Minimum			(Attachment C) Identification of	<u>of</u>	
	Data Set Asses	ssment, dated 3/2/11,			other residents at risk; All residents are at risk of change	in	
	indicated Resid				bowel function resulting less		
					frequent bowel movement than	n	
	cognition impa	annent, was			every 3 days or frequency		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155231	B. WIN			04/06/2011
NAME OF I	DDOVIDED OD SLIDDI IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			701 S C	DAK STREET	
	PH NURSING HOM				IESTER, IN47394	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG		DATE
incontinent of bowel and bladder,				designated by the resident's physician. To promote bowel		
	and required th	ne assistance of the			function monitoring, assessme	ent.
	_	rivities of daily living.			and intervention as indicated,	
		avides of daily living.			nursing staff have been	
					re-inserviced regarding, Nursi	ng
	A health care p	olan problem, dated			Standards which includes "All	
	11/18/09 and 1	ast reviewed on			nursing staff assesses and evaluates the health status of	the
	3/16/11, indica	nted Resident #45			resident/client" and "Makes	
	· ·	constipation related			nursing judgments and decision	ons
		_			about their nursing care for the	e
		nobility and use of			resident/client by using	.
	antipsychotic i	medications. The			assessment data." (Attachmer C)All residents Care Plans we	
	goal for this pr	roblem was for the			reviewed and updated as need	
	resident to hav	re a soft formed stool			by the DON or designee to	
					ensure appropriate monitoring	of
	1 '	ys. Approaches for			bowel movement status,	
	_	ncluded, but were not			assessment and intervention	
	limited to, the	following:			needs are being met. The Director of Nursing or designe	_
					will review all residents bowel	`
	" 3 Monitor:	and record BMs			movement frequency and nurs	sing
					intervention using form, by Ap	ril
	[bowel movem	_			22, 2011 to assure nursing is	
	4. monitor BN	A flow sheet dly			assessing the clinical data, the plan of care, and the need for	
	[daily] for nee	d for laxative			nursing assessment and/or	
	5. If no BM ir	n 3 days give MOM			intervention when needed.	
		esia, a laxative 30			(Attachment H) Measures to	
	-	=			ensure this cited practice does	
		meters] orally dly prn			not recur; All nursing staff have	
	[when needed]				been re-inserviced to Policy & Procedure for Bowel Elimination	
	6. Auccultate ((sic) bowel sounds			(Attachment C) The Director	
		abdominal distention			Nursing or her designee will	
					review all resident charts to	
		naving pain or is			ensure the plan of care for each	
	unable to have	BM			resident meets each resident's most current needs and will	·
	8. Colace (a	stool softener) 100			monitor to assure bowel	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		ONSTRUCTION 00	COMPL	ETED	
NAME OF I	PROVIDER OR SUPPLIER	155231	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/06/2	U11
RANDOLPH NURSING HOME				1	OAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	mg rectally promise in these time periodocumentation Resident #45 in bowel movem mg rectal prn" Bowel monitor Resident #45 in January, February 1 in January 3, 4, 5 in February 11, 1 in March 17, 18, in The nursing not Administration these time periodocumentation Resident #45 in bowel movem During an interpretation of Nursident Poirector of Nursident Poirector of Nursident, additional p.m., additional p.m., additional p.m., additional process in the periodocument p.m., additional process in the periodocument p.m., additional	pp [suppository]10 133 ml [milliliters] ring records for for the months of lary, and March 2011, entation of the g a bowel movement owing time periods: 4, 6, 2011 2, 13, 14, 15, 2011 19, 2011 otes and Medication in Records (MAR) for fods lacked in of any assessment of related to the lack of ents. rview with the			movement frequency is monitored with interventions according to the care plan. (Attachment H) Monitoring of corrective action; The Director Nursing or her designee will monitor to assure appropriate monitoring of resident BM frequency, and assessment at intervention according to resides individualized care plan. (Attachment H) Bowel Movem Monitor will be completed 5 x weekly for 30 days, and 1 time weekly for 90 days in total. Monitoring results will be report of facility administrator as completed and to the QA&A Team weekly, and will become of Randolph Nursing Homes Qua Assurance Program.	nd lent' ent rted	

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COMP			COMPL	ETED
		155231	B. WING 04/06/2011			011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			701 S C	OAK STREET		
	PH NURSING HOM		_		ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	bowel assessm	ents as noted above.					
	During an inte	rview on 4/6/11 at					
		e Director of Nursing					
		nad no information to					
		d to the lack of bowel					
	^						
SS=D	assessments noted above.				F 272 Preparation and/or		04/22/2011
33-D	2.) The clinical record for				execution of this plan of correction in general, or this		04/22/2011
	Resident #30 was reviewed on						
	4/3/11 at 2:40 p.m.				corrective action in particular,	.	
					does not constitute an admissi or agreement by Randolph	ion	
	Diagnoses for Resident #30				Nursing Home of the facts		
	included, but v	were not limited to,			alleged or conclusions set fortl	h in	
	dementia with				this statement of deficiencies.		
	agitation, depr				The plan of correction and specific corrective actions are		
	• • •	ession, and			prepared and/or executed in		
	constipation.				compliance with state and fede	eral	
					laws. Please accept this plan	of	
	A significant c	hange Minimum			correction as our credible		
	Data Set (MDS	S) assessment, dated			allegation of compliance with all regulatory requirements.	י ו	
		ated Resident #30			Assessments are conducted for	or I	
	ĺ	y impaired and			each resident including bowel		
	_	• •			elimination. Corrective action for		
	dependent on t	the staff for toileting.			affected residents Residents #		
		71 11 1 1			& # 30 have been assessed an care plans reviewed and revise		
		Plan problem, dated			as needed to assure monitoring		
	9/29/10, indica	ated Resident #30 had			of bowel movements and	·	
	a potential con	stipation. A goal for			assessment and intervention a		
		vas for the resident to			indicated for the prevention of		
	_	ed stool at least every			constipation. Nursing educatio was provided to reinforce the	"	
		•			necessity of monitoring and		
	3 days with no	undo strain.			following the resident's care pl		
					for promoting bowel function a	nd	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155231	B. WING 04/06/201			011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	NAME OF PROVIDER OR SUPPLIER				DAK STREET		
RANDOI	_PH NURSING HO	ME			IESTER, IN47394		
			_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION
TAG	†	LISC IDENTIFYING INFORMATION)	-	TAG			DATE
	Approaches in	ncluded, but were not			preventing constipation. (Attachment C) Identification of	√f.	
	limited to, mo	nitor and record all			other residents at risk; All	<u>//</u>	
	bowel movem	ents every shift and			residents are at risk of change	in :	
	use daily track	king form, and			bowel function resulting less		
	· .				frequent bowel movement that	n	
		atives per physician's			every 3 days or frequency designated by the resident's		
	orders.				physician. To promote bowel		
					function monitoring, assessme	ent,	
	Signed physic	ian orders for			and intervention as indicated,		
	resident dated	d 2/7/11, included, but			nursing staff have been		
	1	,			re-inserviced regarding, Nursi	ng	
		ed to, Docusate			Standards which includes "All		
	Sodium 100 n	ng, 2 times a day,			nursing staff assesses and evaluates the health status of	th o	
	Miralax, 17 G	rams daily, and Milk			resident/client" and "Makes	uie	
		30 ml daily as needed			nursing judgments and decision	ons	
	1	•			about their nursing care for the		
	for constipation	on.			resident/client by using		
					assessment data." (Attachmer		
	Nurse's notes	and Medication			C)All residents Care Plans we		
					reviewed and updated as need	ded	
		n Record (MAR)			by the DON or designee to ensure appropriate monitoring	of	
	lacked any inc	dication of bowel			bowel movement status,	OI	
	movement, as	sessment, and any			assessment and intervention		
	1	ation interventions.			needs are being met. The		
	Incoded inicale	ation into vontions.			Director of Nursing or designe	e	
					will review all residents bowel		
	During an inte	erview with RN #7, on			movement frequency and nurs		
	4/5/11 at 8:40	a.m., nurse stated if			intervention using form, by Ap	rii	
		are performed they			22, 2011 to assure nursing is assessing the clinical data, the	_	
		•			plan of care, and the need for		
		ed on MAR and in			nursing assessment and/or		
	nurse's notes.				intervention when needed.		
					(Attachment H) Measures to		
	During on inte	orgions with the DM			ensure this cited practice does	_	
	1	erview with the RN			not recur; All nursing staff have		
	Consultant on	4/6/11 at 11 a.m., RN			been re-inserviced to Policy &		
					Procedure for Bowel Elimination	UII.	

l '		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155231	B. WING 04/06/2011					
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
DANDOL		A -		1	DAK STREET			
	.PH NURSING HOM			WINCHESTER, IN47394				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
IAG				IAG	(Attachment C) The Director of			
		acker system, MAR			Nursing or her designee will	<i>^</i>		
	and nurse's no	•			review all resident charts to			
	indication of b	owel movements and			ensure the plan of care for each resident meets each resident's			
	interventions f	For Resident #30 for			most current needs and will	·		
	time periods o	f February 1-5, and			monitor to assure bowel			
	13-17.	- '			movement frequency is			
					monitored with interventions according to the care plan.			
					(Attachment H) Monitoring of			
					corrective action; The Director	of		
					Nursing or her designee will			
		monitor to assure appropriate monitoring of resident BM						
	3.) Rev	Review of a current frequency, and assessment at						
	facility	y policy dated 2003,			intervention according to resid s individualized care plan.	ent		
	provid				(Attachment H) Bowel Movem	ent		
	•	•			Monitor will be completed 5 x weekly for 30 days, 3 items			
		nistrator on 4/5/11			weekly for 30 days, and 1 time weekly for 90 days in total.	•		
	at 1:30	p.m., titled			Monitoring results will be report	rted		
	"BOW	/EL			to facility administrator as completed and to the QA&A			
	ELIM	INATION",			Team weekly, and will become	· I		
	includ	ed, but was not			of Randolph Nursing Homes Qua Assurance Program.	inty		
	limited	d to, the following:						
		Ç						
	"POLICY:							
	I OLICI.							
	It is the po	licy of this facility to						
	manage consti	pation by using						
		uidelines designed to						
	_	eat constipation in						
	Provent and the	ou consupation in						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231	
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE TO 1 S OAK STREET WINCHESTER, IN47394 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OUR residents.	COMPLETION
RANDOLPH NURSING HOME (X4) ID PREFIX TAG Our residents. TO1 S OAK STREET WINCHESTER, IN47394 ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Our residents.	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OUR residents. OUR residents.	COMPLETION
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Our residents. PREFIX TAG PREFIX PREFIX CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OUR residents.	
INTENT:	
INTENT:	
The purpose is to reduce the	
frequency and severity of	
constipation. The goal to maintain	
normal bowel movements per the	
individual's bowel frequency with	
straining at stool less than 25%.	
PROCEDURE	
1. Assess for risk of constipation	
and elimination habits on admission	
using an assessment inventory (see	
assessment inventory).	
2. Complete bowel function diary	
for each resident requiring	
management of constipation (see	
bowel function diary)	
3. Intestinal elimination is to be	
closely on all residents. Nurse	
aides will record in the elimination	
record all bowel movements.	
4. Each night the charge nurse will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	A. BUIL	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2 (ETED	
	PROVIDER OR SUPPLIER		B. WING 04/06/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK STREET					
RANDOL	PH NURSING HOM	1E		WINCH	ESTER, IN47394			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
	eliminated in 1 days. The day nurse then will	s who have not day, 2 days, and 3 and evening charge assess the needs for enemas and treat"						
F0279	resident's compress The facility must docare plan for each measurable object meet a resident's imental and psycholidentified in the comparent of the care plan must are to be furnished resident's highest mental, and psycholidentified under §44 would otherwise bout are not provide exercise of rights at the right to refuse	the results of the velop, review and revise the nensive plan of care. evelop a comprehensive resident that includes tives and timetables to medical, nursing, and osocial needs that are mprehensive assessment. et describe the services that do to attain or maintain the practicable physical, cosocial well-being as 83.25; and any services that de required under §483.25 ed due to the resident's under §483.10, including treatment under §483.10(b)						
SS=D		review and interview, the ensure each resident had health care plan	F02	279	F279 Preparation and/or execution of this plan of correction in general, or this corrective action in particular,		04/22/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

EPSJ11

Facility ID:

000136

If continuation sheet

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		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155231	B. WING			04/06/2011	
NAME OF I	DOWNDED OD SLIDDI IED			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				701 S (OAK STREET		
RANDOLPH NURSING HOME				WINCH	HESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE .	
	•	ress the needs of the			does not constitute an admission agreement by Randolph	ion	
		13 residents reviewed for			Nursing Home of the facts		
	_	of comprehensive health			alleged or conclusions set fort	h in	
	care plans in a sa	mple of 16. (Resident			this statement of deficiencies.		
	#70 and #72)				The plan of correction and		
					specific corrective actions are		
	Findings include:				prepared and/or executed in		
					compliance with state and federal laws. Please accept this plan		
	1) The clinical r	record for Resident #70			correction as our credible		
	· ·				allegation of compliance with	,	
	was reviewed on 4/3/11 at 4:00 p.m. Diagnoses for Resident #70 included, but				all regulatory requirements.		
					Individualized Care Plans are		
					developed for each resident to)	
		to, history of aspiration			address the needs of the		
	pneumonia, chro	nic respiratory failure			resident. Corrective action for		
	with status post t	racheostomy, paraplegia,			affected residents Upon return from the hospital resident #70		
	and diabetes mel	litus. The clinical record			be assessed relating to his	VVIII	
	indicated the resi	dent received nutrition			diagnosis of chronic respirator	y	
	via a gastrostomy	y tube, had an anchored			failure with status post		
	catheter, and had				tracheostomy and possible		
	Ź	3			respiratory complications for		
	Admission orders	s_dated 3/25/11			which resident #70 should be monitored and the physician		
		t #70 was to receive			notified if indicated.Resident #	72	
					care plan has been updated to		
		28% via tracheostomy			include toileting needs,		
	(trach) and be give	ven trach care every shift.			monitoring of bowel patterns for		
		D . G .			possible constipation and need		
	An admission Mi				for administration of medicatio as ordered by the physician. S		
	-	ed 4/1/11, indicated			(Attachment B). Identification of		
		s totally dependent on the			other residents at risk; All nurs		
	staff for all activi	ities of daily living and			staff will be re-inserviced (as o	f	
	had a tracheostor	my.			April 22, 2011) regarding facilit		
					P&P on Care Planning which		
	A nursing note, d	lated 3/27/11 at 1:00			includes; addressing the need the resident in the individualize		
		esident #70's lungs were			resident care with measureabl		
	-	_			goals. (Attachment C) All	·	
	clear and no signs and symptoms of				<u>, </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
		155231	B. WING 04/06/2011			011		
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
DANDO		AF		1	DAK STREET			
RANDOI	_PH NURSING HO	VIE		WINCH	IESTER, IN47394			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	infection were n	oted. The note indicated			residents Plan of Care will be			
	the resident's ten	nperature was within			reviewed to ensure the monitor	ring		
	normal limits.				of bowel patterns for possible			
	normar mints.				constipation and need for			
		1 . 10/00/11 . 5 05			administration of medications	as		
	_	dated 3/28/11 at 7:35			ordered by the physician. (Attachment D)All residents Pl	on		
	p.m., indicated "	lungs with coarse			of Care will be reviewed to en			
	crackles, produc	tive cough noted at times,			those residents, identified with			
	trach care given.	small amount of thick			chronic respiratory failure and			
	yellow sputum n				related complications, have a			
)				comprehensive health care pla	an		
	A nursing note, dated 3/29/11 at 8:40				which will include post			
					tracheostomy care and possib	le		
	1 * '	lungs with bilateral			respiratory complications for			
	crackles suction	oned times 3 this shift			which the resident should be			
	with large amou	nts of thick yellow			monitored and the physician			
	sputum, inner ca	nula changed times 2"			notified if indicated. (Attachme	ent		
		\mathcal{E}			E)Measures to ensure this deficient practice does not			
	A nursing note	dated 3/30/11 at 4:00			recur; All nursing staff will be			
	_				re-inserviced (as of April 22,			
	1 *	he resident had developed			2011) regarding facility P&P o	n		
	a temperature of				Care Planning which will inclu			
	temperature not	noted) and Tylenol had			Problems must be specifically			
	been given. The	note indicated "lungs			care planned; All goals bust be			
	crackles in lower	r lobes" A follow-up			measurable. (attachment C).			
		indicated the resident's			Monitoring of corrective			
	1	now 100.9 and Tylenol			action; Upon return to the facil	•		
	1 ^	now 100.7 and Tylenoi			the individualized care plan for resident #72 will be reviewed			
	was given.				the DON and revised to addre	•		
					the needs of the resident	00		
	The clinical reco				including but not limited to chr	onic		
	information rela	ted to the physician being			respiratory failure with post	•		
	notified of the residents yellow sputum				tracheostomy and treatments	or		
	and elevated tem	•			monitoring indicated for this			
		•			resident. The IDT will review			
	The current heal	th care plans for Desident			resident # 72's care plan to			
		th care plans for Resident			assure inclusion of pertinent			
	· ·	11 and 3/30/11, lacked			information. The Director of			
	any comprehens	ive health care planning			Nursing or her designee will			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	00	COMPL		
THIE TEAM	or condition	155231	1	LDING		04/06/2	
			B. WIN		DDDESS CITY STATE ZID CODE	1 00,2	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HON	1E	WINCHESTER, IN47394				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	· ·				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
PREFIX TAG	related to the resichronic respirator tracheostomy rechumidification at treatments, trache and possible respirator the physician deposition of the physician deposition of the physician development of plan of care rechronic respirator tracheostomy. The facility fair additional information of the physician development of the plan	cy Must be perceded by full LSC IDENTIFYING INFORMATION) ident's diagnosis of ry failure with status post quiring the need for to 28%, frequent nebulizer eostomy care twice daily, piratory complications for the should be monitored in notified if indicated.		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	to g t ts, 5 kly 90 and s,	COMPLETION DATE
	'	wed on 4/4/11 at 3:30					
	Diagnoses for included, but v	were not limited to,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
		155231	A. BUII B. WIN	LDING G		04/06/2	
NAME OF P	PROVIDER OR SUPPLIER		p. ((n)	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PH NURSING HOM			1	OAK STREET ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	LOTEIX, IIV 4 7 334		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG				TAG	DEFICIENCY)		DATE
	dementia, aphasia and dysphasia.						
A quarterly Minimum Data Set (MDS)Assessment, dated 1/13/11,							
	indicated Resid	dent #72 rarely made					
	decisions, was	incontinent of					
		owel, and required					
	the assistance	of the staff for all					
	activities of daily living.						
	12/31/11, indic	start reg [regular]					
	Current physic	eian's orders for					
	Resident #72 i	ncluded, but were not					
	limited to, Bisa	acodyl (a laxative) 5					
		gs) one tablet every					
	morning routir	nely and Bisacodyl 10					
		y one rectally every 2					
	-	l. The original date					
	of these orders	was 1/1/11.					
	3/29/11, indicate Huntington's d	Plan problem, dated ated Resident #72 had disease and was					
	_	the staff to meet his oblem indicated					

000136

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 70.4.0. CANCOLDEET.	
RANDOLPH NURSING HOME 701 S OAK STREET WINCHESTER, IN47394	
CROSS-REFERENCED TO THE APPROPRIATE	(X5) DMPLETION DATE
Resident #72 was at risk for multiple problems including, but not limited to, constipation. The only goal for this problem was "I will be clean and neat in my appearance." The approaches for this problem lacked any information related to the need to assist Resident #72 with toileting, monitor his bowel pattern for possible constipation, administer his daily laxative medication, and administer the Bisacodyl suppository if needed as ordered by the physician for constipation. During an interview with the Director of Nursing, MDS Coordinator, and Administrator on 4/5/11 at 11:15 a.m., additional information was requested related to the lack of a comprehensive health care plan having been developed for Resident #72 related to bowel and constipation concerns. The MDS Coordinator indicated the facility was in the process of	DAIE

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Event ID:

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Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI						
THIS TETAL	or connection	155231	A. BUII B. WIN	ILDING 04/06/201				
NAME OF F	AD CLUDED OD CLUDDI IED		D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER			701 S OAK STREET				
RANDOL	.PH NURSING HOM	1E		WINCH	IESTER, IN47394			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	
		e "I" format for						
	health care pla	nning which						
	combined mul	tiple areas and						
	Resident #72's	health care plan had						
	been complete	d in this format.						
	The facility fai	iled to provide any						
additional information as of exit on 4/6/11.								
SS=D	facility provid 4/5/11	view of a current y policy dated 2003, led by Admin on at 1:30 p.m., titled		F279 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by Randolph Nursing Home of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and			04/22/2011	
	"CAR	E PLANNING",			specific corrective actions are prepared and/or executed in			
	includ	ed, but was not			compliance with state and federal laws. Please accept this plan			
	limited	d to, the following:			correction as our credible			
	Health meetir	CY: erdisciplinary a Care Plan ags are scheduled ely and after a			allegation of compliance with all regulatory requirements. Individualized Care Plans are developed for each resident to address the needs of the resident. Corrective action for affected residents Upon return from the hospital resident #70 be assessed relating to his diagnosis of chronic respirator failure with status post tracheostomy and possible respiratory complications for	will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231		(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE S COMPLI 04/06/20	ETED		
	ROVIDER OR SUPPLIER		,	701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET IESTER, IN47394	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	signif	icant change in a			which resident #70 should be monitored and the physician			
	reside	nt's condition to		notified if indicated.Resident #72 care plan has been updated to				
	enable	e the staff, family			include toileting needs, monitoring of bowel patterns	for		
	and re	esidents to develop			possible constipation and nee	ed		
	an inte	erdisciplinary plan			for administration of medication as ordered by the physician. (Attachment B). Identification of the strength o	See		
	that w	ould allow the			other residents at risk; All nur	sing		
	reside	nt to reach his/her			staff will be re-inserviced (as April 22, 2011) regarding facil			
	highest level of mental,				P&P on Care Planning which includes; addressing the need			
		cal, spiritual and			the resident in the individualiz	red		
		•			resident care with measureab goals. (Attachment C) All	ole		
	psych	osocial			residents Plan of Care will be			
	well-b	peing			reviewed to ensure the monitor of bowel patterns for possible constipation and need for	~ I		
					administration of medications	as		
	CAI	RE PLANNING:			ordered by the physician. (Attachment D)All residents P	lan		
	All	problems identified			of Care will be reviewed to er	sure		
	must l	be specifically care			those residents, identified with chronic respiratory failure and			
	planne	ed, including			related complications, have a comprehensive health care pl			
	indivi	dualized nursing			which will include post tracheostomy care and possil	ole		
	measu	ires to be carried out			respiratory complications for which the resident should be			
	to the	execute the plan. If			monitored and the physician notified if indicated. (Attachmo	ent		
	you are having difficulty with deciding what the				E)Measures to ensure this deficient practice does not			
					recur; All nursing staff will be re-inserviced (as of April 22,			
	proble	em is, consider why			2011) regarding facility P&P on Care Planning which will include;			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155231	B. WIN			04/06/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
					DAK STREET		
	.PH NURSING HOM	1E		WINCH	IESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	
IAU		· · · · · · · · · · · · · · · · · · ·	+	IAU	Problems must be specifically	DATE	
		storative measures			care planned; All goals bust be	•	
	are ne	cessary. This			measurable. (attachment C). Monitoring of corrective		
	should	guide you to the			action; Upon return to the facil	-	
	proble	m or needs			the individualized care plan for resident #72 will be reviewed by		
	proble	m or needs.			the DON and revised to address	-	
					the needs of the resident		
	A 11	goals must be			including but not limited to chro	onic	
	All	goals must be			respiratory failure with post tracheostomy and treatments of	nr	
	measu	rable and			monitoring indicated for this		
	interve	integrantions need to be		resident. The IDT will review resident # 72's care plan to			
	care planned and match				assure inclusion of pertinent		
	-	erventions being			information. The Director of Nursing or her designee will		
		· ·			complete random chart audits assure appropriate	to	
		d out by staff.			comprehensive care plan		
	One-to	o-one activities			development addressing the needs of the resident including		
	must b	e specifically			risk of constipation and risk of chronic respiratory failure post		
	planne	ed and show who			tracheostomy as applicable. (Attachment D & E) Five charts		
	will be	e doing what with a			x weekly for 30 days, 3 x week	ly	
	reside	nt and when.			for 30 days, 1 time weekly for 9 days in total. Findings will be		
					reported to the Administrator a	I	
					QA&A team on a weekly basis and will become part of Randolph		
		eas to initially			Nursing Homes Quality Assurance		
	addres	s are:			Program.		
	a.	Psychosocial well					
	being						
	b.	Mood/behavior					
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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO LDING	00	COMPL	
		155231	B. WIN			04/06/2	011
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE OAK STREET		
RANDOL	PH NURSING HO	ME			ESTER, IN47394		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	c.	Communication					
	abiliti	es and motivation					
	d.	Sensory					
	impai	rments					
	e.	Cognitive					
	functi	oning					
	f.	Customary routine					
	of resi	ident					
	g.	Psychoactive					
	medic	ations					
	h.	Physical restraints					
	i.	Discharge					
	planni	ing"					
	reside	ent. Staff members					
	showi	ng any trend toward					
	impat	ience or frustration					
	in rou	tine dealings with					
	reside	nts should be					
	evalua	ated for possible					
	tempo	orary assignment or					
	unpai	d leave of absence					
	"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/06/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK STREET WINCHESTER, IN47394				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F0309	must provide the r to attain or mainta physical, mental, a	st receive and the facility necessary care and services in the highest practicable and psychosocial					
SS=D	Based on reco- interview, the ensure residen for constipation monitored in or physician order when necessar constipation for reviewed for b	rd review and facility failed to ts identified at risk on had their bowels order to administer tred interventions	F0309	F 309Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admis or agreement by Randolph Nursing Home of the facts alleged or conclusions set for this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fee laws. Please accept this pla correction as our credible	rth in decorated and of		
	Findings inclu 1.) The clinica #45 was review p.m. Diagnoses for included, but v	al record for Resident wed on 4/5/11 at 2:30		allegation of compliance wi all regulatory requirements. Corrective action for affected residents Resident #45 & res #30 have been assessed for active bowel sounds. All nurs staff has been re-inserviced to Policy & Procedure for Bowe Elimination. (Attachment C) Identification of other residen risk; All nursing staff have be re-inserviced to Policy & Procedure for Bowel Eliminat (Attachment C) The Director Nursing or her designee will review all resident charts to	ident sing to I ts at een		

´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155231	B. WIN	G		04/06/2011
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	ROVIDER OR SOLITEIER			1	DAK STREET	
RANDOL	PH NURSING HOM	1E		WINCH	IESTER, IN47394	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE .
	A Significant (Change Minimum			ensure the plan of care for each resident meets each residents	
		ssment, dated 3/2/11,			most current needs and intervention are being followed	
					according to the care plan.	`
	indicated Resid				(Attachment H) Measures to	
	cognition impa	airment, was			ensure this deficient practice	_
	incontinent of	bowel and bladder,			does not recur; All nursing state have been re-inserviced to Pol	
	and required th	ne assistance of the			& Procedure for Bowel	licy
	•	ivities of daily living.			Elimination. (Attachment C) T	he
		ivines of daily living.			Director of Nursing or her	
	A 1 1.1	1 11 1 1			designee will review all resider charts to ensure the plan of ca	
	•	olan problem, dated			for each resident meets each	ie
	11/18/09 and 1	ast reviewed on			resident's most current needs	
	3/16/11, indica	ited Resident #45			and will monitor to assure	
	was at risk for	constipation related			interventions are being followe	ed
		nobility and use of			according to the care plan. (Attachment H) Monitoring of	
		•			corrective action; The Director	of
		medications. The			Nursing or her designee will	
	-	oblem was for the			monitor to assure appropriate	
	resident to hav	e a soft formed stool			monitoring of resident BM frequency, and assessment ar	nd
	every three day	ys. Approaches for			intervention. (Attachment H)	14
	this problem in	ncluded, but were not			Monitoring be the DON or	
	limited to, the				designee will be completed 5 >	(
	, , , , , , , , , , , , , , , , , , , ,	10110 W 1115.			weekly for 30 days, 3 items weekly for 30 days, and 1 time	,
	 	11DM			weekly for 90 days in total.	
		and record BMs			Monitoring results will be report	
	[bowel moven	-			to the QA&A Team weekly, and	l
	4. monitor BN	I flow sheet dly			will become part of Randolph Nursing Homes Quality Assurance	
	[daily] for nee	d for laxative			Program.	PG
	- * -	a 3 days give MOM				
	[milk of magnesia, a laxative] 30					
		=				
	-	meters] orally dly prn				
	[when needed]					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/06/2011			
	PROVIDER OR SUPPLIER		D. WIW	STREET A	DAK STREET ESTER, IN47394	 	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL I.S.C. IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
PREFIX TAG	6. Auccultate (and assess for if residents is lunable to have8. Colace (amgs twice dailDulcolax Sumg rectally promise in the second se	(sic) bowel sounds abdominal distention naving pain or is BM stool softener) 100 y pp [suppository]10 n 133 ml [milliliters] on of physician's h/2/11, indicated had the following orders which all had red date of 6/10/10: 10 mg one rectally constipation 33 mls rectally as or constipation esia 30 cc as needed days		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION DATE
	Resident #45 f	ring records for For the months of lary, and March 2011, entation of the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 04/06/2	ETED	
	PROVIDER OR SUPPLIER		B. WING	STREET A	DAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		g a bowel movement owing time periods:					
	January 3, 4, 5 February 11, 1 March 17, 18,	2, 13, 14, 15, 2011					
	Administration these time periodocumentation	of any assessment of					
	bowel movem information re	related to the lack of ents or any lated to the physician entions having been					
	Director of Nu Administrator p.m., additiona requested relat	rview with the arsing and on 4/5/11 at 4:15 al information was seed to the lack of ents noted above.					
	11:00 a.m., the indicated she h	rview on 4/6/11 at e Director of Nursing had no information to d to the lack of bowel sted above.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM		COMPL	MPLETED	
		155231	B. WIN			04/06/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l	DAK STREET		
DANDOL	PH NURSING HOM	∧ ⊏		l	ESTER, IN47394		
				WINCH	ESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	 	TAG	DEFICIENCY)		DATE
SS=D	Diagnoses for included, but we dementia with agitation, depresent constipation. A significant of Data Set (MDS 2/24/11, indicated was cognitively dependent on the A Health Care 9/29/10, indicated a potential conthis problem we have soft form 3 days with no Approaches in limited to, more	was reviewed on p.m. Resident #30 were not limited to, behaviors and ression, and change Minimum S) assessment, dated ated Resident #30 y impaired and the staff for toileting. Plan problem, dated ated Resident #30 had astipation. A goal for was for the resident to red stool at least every			F 309Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admissior agreement by Randolph Nursing Home of the facts alleged or conclusions set forth this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fedelaws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. Corrective action for affected residents Resident #45 & residents Resident #45 & residents have been assessed for active bowel sounds. All nursis staff has been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) Identification of other residents risk; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) Identification of other residents risk; All nursing staff have been re-inserviced to Policy & Procedure for Bowel Elimination. (Attachment C) The Director of Nursing or her designee will review all resident charts to ensure the plan of care for eacresident meets each residents most current needs and intervention are being followed.	eral of dent ng on. of	04/22/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155231	A. BUILDING		00	04/06/2011	
		100201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 1/00/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	DAK STREET		
	PH NURSING HON			1	ESTER, IN47394		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
	use daily track				according to the care plan. (Attachment H) Measures to		
	administer lax	atives per physician's			ensure this deficient practice		
	orders.				does not recur; All nursing sta		
					have been re-inserviced to Pol & Procedure for Bowel	licy	
	Signed physici				Elimination. (Attachment C) T	he	
	· ·	1 2/7/11, included, but			Director of Nursing or her designee will review all resider		
		ed to, Docusate			charts to ensure the plan of ca		
		ng, 2 times a day,			for each resident meets each		
	Miralax, 17 Grams daily, and Milk				resident's most current needs and will monitor to assure		
	of Magnesia, 3	30 ml daily as needed			interventions are being followe	ed	
	for constipatio	n.			according to the care plan. (Attachment H) Monitoring of		
					corrective action; The Director	of	
	Nurse's notes a	and Medication			Nursing or her designee will		
	Administration	n Record (MAR)			monitor to assure appropriate monitoring of resident BM		
	lacked any ind	lication of bowel			frequency, and assessment ar	nd	
	movement, ass	sessment, and any			intervention. (Attachment H) Monitoring be the DON or		
	needed medica	ation interventions.			designee will be completed 5 x weekly for 30 days, 3 items	(
	Desmin e e e is é				weekly for 30 days, and 1 time	,	
	-	erview with RN #7, on			weekly for 90 days in total. Monitoring results will be repore	ted	
		a.m., nurse stated if			to the QA&A Team weekly, and		
		are performed they			will become part of Randolph		
		ed on MAR and in			Nursing Homes Quality Assuranc Program.	ee	
	nurse's notes.						
	During an	interview with the RN					
	Consul	tant on 4/6/11 at 11					
	a.m R	N stated Care Tracker					
		, MAR and nurse's					
	System,	, with and nuises					

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 04/06/2	LETED
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME		D. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	notes la	acked any indication					
	of bow	el movements and					
	interve	ntions for Resident					
	#30 for	time periods of					
	Februa	ry 1-5, and 13-17.					
	facility provid 4/5/11 "BOW ELIM includ	ew of a current y policy dated 2003, led by Admin on at 1:30 p.m., titled //EL INATION", ed, but was not d to, the following:					
	_	licy of this facility to pation by using					
	_	uidelines designed to					
	_	eat constipation in					
	our residents.						
	INTENT:						

I '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 04/06/2	LETED
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			•	701 S C	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394	•	
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	The purpo frequency and constipation. normal bowel individual's be straining at stee PROCEDURI 1. Assess for and elimination using an assessment in 2. Complete It for each reside management of bowel function3. Intestinal closely on all aides will record all bow 4. Each night list all resident eliminated in days. The day	se is to reduce the severity of The goal to maintain movements per the owel frequency with pool less than 25%. E risk of constipation on habits on admission sment inventory (see wentory). bowel function diary ent requiring of constipation (see		IAU			DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155231		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI 04/06/20	ETED		
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK STREET WINCHESTER, IN47394					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	laxatives and eappropriately 3.1-37(a)	enemas and treat "					
SS=D	provides food prepage meet individual need assed on recomposervation, at facility failed areceived thick ordered by the possible swall and/or aspiration residents reviet thickened lique (Resident #72). Findings inclusively was reviewed p.m. Diagnoses for	rd review, and interview, the to ensure a resident ened liquids as a physician to prevent owing problems on for 1 of 3 ewed with orders for ids in a sample of 16. de: al record for Resident wed on 4/4/11 at 3:30 Resident #72 were not limited to,	F0365	F365 Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute an admis or agreement by Randolph Nursing Home of the facts alleged or conclusions set for this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fellaws. Please accept this pla correction as our credible allegation of compliance wi all regulatory requirements. Food is prepared in a form to meet the individual needs. Corrective action for affected resident; Dietary and Nursing Staff have been re-educated following tray cards provided each resident meal tray inclu appropriate consistency and serving method for pudding t liquids. (Attachment C.) FSE designee monitors to assure Resident #72 receives his metray fluids in appropriate	sion rth in s. e deral n of th for ding hick or	04/22/2011	

STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLET	ΓED
		155231	B. WIN			04/06/20 ⁻	11
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	OAK STREET		
RANDOLPH NURSING HOME					HESTER, IN47394		
RANDOLFH NORSING HOWE							
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	dementia, aph	asia and dysphasia.			consistency and delivery device	ce	
					as ordered by physician. Identification of other residents	o ot	
	A physician's	order dated 1/7/11			risk; All residents with thicken		
	1 ^ *	order, dated 1/7/11			liquid diet orders are at risk.		
	indicated resid	dent #72 was to			Resident Diet tray cards were		
	receive a pure	ed diet with pudding			reviewed April 22, 2011 by the		
	thick liquids.	1 &			FSS or her designee to ensure	e	
	unck fiquids.				meals served are following me		
					slips provided for each resider		
	A quarterly M	inimum Data Set			meal tray. Dietary and Nursin	g	
	Assessment, d	lated 1/13/11			Staff have been inserviced to	,	
	1	<i>'</i>			Policies & Procedures Tray I.I Cards to ensure each tray).	
		dent #72 rarely made			properly identifies each reside	nt's	
	decisions, reco	eived a mechanically			needs and including appropriate		
	altered diet, a	nd required the			consistency and serving meth		
	1	he staff for all			for pudding thick liquids.		
					Measures to ensure this defici		
	activities of da	aily living.			practice does not recur; Dieta	ry	
					and Nursing Staff have been		
	A Health Care	Plan problem, dated			inserviced to Policies & Procedures and Tray I.D. Care	10	
		_			to ensure each tray properly	15	
	1	ated Resident #72 had			identifies each resident's need	ls.	
	problems with	a protruding tongue			including appropriate consiste		
	causing him to	o drool on his self and			and serving method for puddir	ng	
	was at risk for				thick liquids. (Attachment C)		
		· ·			Resident Diet tray cards were	be	
	aspirating who	en consuming food			reviewed by the FSS or her	oina	
	and drinks. A	pproaches for this			designee April ,2011 and ong monitoring will continue to	oirig	
		ded, but were not			ensure meals served are		
	1 ^				following meal slips provided f	or I	
		will be fed by staff my			each resident meal tray includ		
	pureed diet wi	ith pudding thick			appropriate consistency and		
	liquids"				serving method for pudding th	ick	
	1				liquids. Monitoring will be		
		4/2/44			completed5x weekly for 30 days		
	During an obs	ervation on 4/3/11 at			3 times weekly for 30 days, 1 weekly for 90 days in	ume	
	5:35 p.m., Res	sident #72 was up in			total. (Attachment G) Monitori	ng	

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 04/06/2 (ETED
NAME OF PR RANDOLF (X4) ID PREFIX TAG	ROVIDER OR SUPPLIER PH NURSING HOM SUMMARY S' (EACH DEFICIENCE REGULATORY OR his reclining gedining room by station. The statay and was p The meal slip of indicated the re receive a pure of thick liquids. had been sent to was with the re resident had a large glass of of tomato juice w and had not be #4 indicated R like tomatoes a get him some of CNA #3 return milk and gave was preparing sippy cup. Wh the use of a sign thick liquids, of indicated they	IDENTIFICATION NUMBER: 155231 IE TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) eri chair in the small by the 300 hall nursing reparing to feed him. on the resident's tray resident was to red diet with pudding A large sippy-cup from the kitchen and resident's tray. The pureed diet and a ref tomato juice. The ras in regular form ren thickened. CNA resident #72 did not rend asked CNA #3 to rehocolate milk. red with the chocolate rit to CNA #4 who re pour it into the ren queried regarding repy cup with pudding CNA #3 and CNA #4 always used a sippy	ľ	LDING G STREET A 701 S C		COMPLI 04/06/20 04/06/20 or tray are or ing ing ick	ETED
	•	nt #72 and were sident's liquids were d.					

Facility ID:

AND PLAN OF CORRECTION ID		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	A. BUII	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/06/2	ETED
NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE DAK STREET ESTER, IN47394		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
SS=D	the CNAs that liquids could ra sippy cup an obtain some that the chocolate raconsistency. On ursing station container of pand thickened pudding thick The resident caserving of pudmilk. 2.) Refacility 2003, DoN on p.m., to "THIO LIQUE	onsumed the entire ding thick chocolate view of a current y policy, dated provided by the on 4/4/11 at 4:35 itled CKENED IDS", included, but of limited to, the			F365 Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admissi or agreement by Randolph Nursing Home of the facts alleged or conclusions set forti this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and fede laws. Please accept this plan correction as our credible allegation of compliance with all regulatory requirements. Food is prepared in a form to meet the individual needs. Corrective action for affected	h in eral of	04/22/2011

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I '		X1) PROVIDER/SUPPLIER/CLIA	l i		X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155231	B. WING		04/06/2011	
MARGORY	DOLUDED OF GURDI TO	Ш	STREET	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIER		701 S	OAK STREET		
RANDOL	PH NURSING HON	1E		HESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	DROUDDING W. CV. OF CORP.	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	"PURPO	SE:		resident; Dietary and Nursing Staff have been re-educated t	o	
	To optima	ize the therapeutic		following tray cards provided t		
	benefit of co	•		each resident meal tray include appropriate consistency and	ing	
				serving method for pudding th	ick	
		or swallowing		liquids. (Attachment C.) FSD		
	disorders and	d to assure the		designee monitors to assure		
	residents wit	th orders for such		Resident #72 receives his me tray fluids in appropriate	di	
				consistency and delivery devi	ce	
	thickeners as	_		as ordered by physician.		
	consistent ar	nd appropriate		Identification of other resident		
	treatment ac	cording to		risk; All residents with thicken liquid diet orders are at risk.	ea	
		•		Resident Diet tray cards were		
	physician or	aer		reviewed April 22, 2011 by the		
				FSS or her designee to ensur		
	3.1-21(a)(3)			meals served are following me		
	3.1 - 21(a)(3)			slips provided for each resider meal tray. Dietary and Nursin	ı	
				Staff have been inserviced to	9	
				Policies & Procedures Tray I.I	D.	
				Cards to ensure each tray		
				properly identifies each reside	I	
				needs and including appropriations consistency and serving meth		
				for pudding thick liquids.	ou	
				Measures to ensure this defic	ent	
				practice does not recur; Dieta	I	
				and Nursing Staff have been		
				inserviced to Policies &	.	
				Procedures and Tray I.D. Car to ensure each tray properly	as	
				identifies each resident's need	ds.	
				including appropriate consiste	· I	
				and serving method for pudding	-	
				thick liquids. (Attachment C)	.	
				Resident Diet tray cards were	be	
				reviewed by the FSS or her designee April ,2011 and ong	oing	
				monitoring will continue to	onig	
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	EPSJ11 Facility	<u> </u>	heet Page 91 of 92	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		00	COMPLETED	
		155231	A. BUILDING		04/06/2011	
			B. WING		1	
NAME OF I	PROVIDER OR SUPPLIER	t .		EET ADDRESS, CITY, STATE, ZIP CODE		
				S OAK STREET		
RANDOL	PH NURSING HON	ΛE	WIN	NCHESTER, IN47394		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	ensure meals served are following meal slips provided each resident meal tray included appropriate consistency and serving method for pudding the liquids. Monitoring will be completed5x weekly for 30 days, 1 weekly for 90 days in total. (Attachment G) Monitoring of corrective action: The FSS her designee will monitor Diecards to ensure meals served following meal slips provided each resident meal tray included appropriate consistency and serving method for pudding the liquids. (Attachment G) Monitoring will be completed during Breakfast, Lunch or Supper, at least 5x weekly for days, 3 times weekly for 90 days in the Findings will be reported to the QA&A team weekly, and will become part of Randolph Nursing Homes Quality Assurance Programmeters.	for ding nick ays, time ing or t tray I are for ding nick	